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In The
Supreme Court of the United States

SAN LAZARO ASSOCIATION, INC., OGANES NAGAPETYAN, KHACHIK SIMONYAN, AND CLINICAL CARE LABORATORY, INC.,

Petitioners,

vs.

THE DIRECTOR OF THE STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES AND THE CONTROLLER OF THE STATE OF CALIFORNIA,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, for purposes of maintaining a civil rights action, providers of Medicaid services, such as petitioners, whose Medicaid payments are withheld as a result of postpayment reviews and investigations of their Medicaid claims by a state agency *other than* the designated "single state Medicaid agency," are intended beneficiaries of federal Medicaid statutes and regulations requiring such reviews to be conducted by the single state Medicaid agency, itself.

2. Whether, in any event, providers of Medicaid services, such as petitioners, may maintain a cause of action in federal court under a federal preemption-based argument challenging the state actions withholding their Medicaid payments based on postpayment reviews performed by state agencies other than the single state Medicaid agency.

LIST OF PARTIES AND RULE 29.6 DISCLOSURE

Among the nongovernmental parties to the proceedings below were two corporations, San Lazaro Association, Inc., and Clinical Care Laboratory, Inc. At all relevant times, each corporation was a privately owned California corporation. No stockholder of either corporation was ever a publicly owned corporation.

The other parties below were petitioners, Khachik Simonyan and Oganes Nagapetyan, and respondents, the Director of the California State Department of Health Services and the Controller of the State of California.

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PETITION FOR WRIT OF CERTIORARI

Petitioners San Lazaro Association, Inc. ("San Lazaro"), Oganes Nagapetyan ("Nagapetyan"), Khachik Simonyan ("Simonyan") and Clinical Care Laboratory, Inc. ("Clinical Care") respectfully pray that a Writ of Certiorari issue to review the opinion of the United States Court of Appeals for the Ninth Circuit, filed January 24, 2002, and amended April 17, 2002. A timely filed Petition for Rehearing and Suggestion for Rehearing En Banc was denied on April 17, 2002.

OPINIONS BELOW

The amended published opinion of the United States Court of Appeals, Ninth Circuit, is reported at 286 F.3d 1088 (9th Cir. 2002) and is reprinted in the Appendix at 1-29. The April 9, 2002 Order of the Court of Appeals denying the Petition for Rehearing and the Suggestion for Rehearing En Banc is reprinted in the Appendix at 2-4. The April 17, 2002 Judgment of the Court of Appeals is reprinted in the Appendix at 30-31. The Memorandum opinions and Judgments of the United States District Court for the Central District of California, which were reversed by the Court of Appeals on April 17, 2002, are reprinted in the Appendix at 32-82.

JURISDICTION

The Court of Appeals filed its original opinion on January 24, 2002. It denied rehearing and rehearing en banc on April 9, 2002, and thereafter issued an amended opinion and amended judgment on April 17,

2002. Petitioners invoke this Court's jurisdiction under 28 U.S.C. Section 1254(1).

THE RELEVANT FEDERAL MEDICAID STATUTES AND REGULATIONS

A. MEDICAID PROGRAM ADMINISTRATION

This case involves the administration of the Medicaid program, Title XIX of the Social Security Act, 42 U.S.C. Sections 1396 *et seq.* and 42 C.F.R. Sections 430.1 *et seq.* [1999]. The Medicaid program is jointly administered by the federal and state governments. Each state is required to establish a state Medicaid plan, which imposes mandatory duties on each state regarding the administration of its Medicaid program. 42 U.S.C § 1396a(a)(1) and 42 C.F.R. § 430.10 [1999]. Appendix at 86.

A state Medicaid plan must contain various provisions required by the controlling federal Medicaid laws and regulations. *See* 42 U.S.C. §§ 1396a(a)(1)-(65), and 42 C.F.R. §§ 431.1 *et seq.* [1999]. These federal state plan requirements are supreme to state law requirements regarding the administration of the Medicaid program. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 501 (1990).

Among the federal requirements is that each state Medicaid plan must designate a single state agency to administer or supervise the administration of its state plan. 42 U.S.C. § 1396a(a)(5), Appendix at 83. Under 42 C.F.R. Section 431.10(e) (Appendix at 88), the designated single state agency "must not delegate, to other than its own officials, authority" to "exercise administrative discretion" in the administration of the state Medicaid plan.

The mandatory prohibition against delegating discretionary authority is subject to a few, very specific exceptions including, for example, the single state agency may delegate the decision-making regarding eligibility for medical assistance to a local agency subject to the supervision of the single state Medicaid agency. *See* 42 U.S.C. § 1396a(a)(5). Appendix at 83. Other specific exceptions to the prohibition against delegation of discretionary authority by the single state Medicaid agency include the right to delegate the responsibility for establishing and maintaining health and other standards for Medicaid providers to another state agency. *See* 42 U.S.C. § 1396a(a)(9) and 42 C.F.R. § 431.610 [1999]. Appendix at 83-84, 91-92. *See also* 42 C.F.R. §§ 431.615, 431.621, and 431.630 [1999], all of which expressly allow the single state Medicaid agency to enter into relationships with other state agencies permitting the delegation of discretionary authority. However, these interagency relationships must be described in the state Medicaid plan. For example, *see* 42 C.F.R. § 431.610(b) and (c) [1999], Appendix at 91-92. There is no express exception for conducting postpayment reviews, *i.e.*, provider audits.

In addition to requiring each state Medicaid plan to describe the relevant interagency relationships, the state Medicaid plan must also describe the organization and functions of the single state Medicaid agency, itself, and its personnel and supporting staff. *See* 42 U.S.C. § 1396a(a)(22) and 42 C.F.R. § 431.11(c) [1999]. Appendix at 84, 90-91.

State plan amendments must be submitted by the single state Medicaid agency and approved by the United States Department of Health and Human Services ("U.S. DHHS") when there are material changes in the

organization or policy of the state Medicaid program. *See* 42 C.F.R. § 430.12(c)(1)(ii) [1999]. Appendix at 86. Plan amendments, which do not affect Medicaid eligibility or payment methods and standards, become effective on the date requested by the single state Medicaid agency so long as the U.S. DHHS approves the plan amendment. *See* 42 C.F.R. § 430.20(b)(3) [1999]. Appendix at 87.

B. THE REQUIRED FEDERAL MEDICAID CLAIMS PROCESSING AND AUDIT PROCEDURES

Each single state Medicaid agency *must* provide for Medicaid claims payment procedures which assure that claims are paid on a timely basis. However, the state plan *must* also provide for procedures for prepayment and postpayment claims reviews to insure the proper and efficient payment of claims and management of the Medicaid program. 42 U.S.C. § 1396a(a)(37) and 42 C.F.R. § 447.45 [1999], Appendix at 85 and 92-96. Under 42 C.F.R. Section 447.45(f), Appendix at 96, postpayment claims reviews must *meet* the requirements of Parts 455 and 456 of Title 42 of the Code of Federal Regulations.[1]

Part 455 of Title 42 of the Code of Federal Regulations requires the *single state Medicaid agency* to establish methods and standards for identifying and investigating suspected cases of fraud and abuse that "do not infringe on

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[1] To facilitate the postpayment (and prepayment) reviews required to be conducted by the single state Medicaid agency, the state Medicaid plan requires agreements pursuant to which health care providers must maintain certain records and must furnish those records and other information *to the single state Medicaid agency*. *See* 42 U.S.C. § 1396a(a)(27). Appendix at 84-85.

the legal rights of persons involved," and "afford due process of the law." *See* 42 C.F.R. § 455.13 [1999], Appendix at 97. Moreover, the single *state Medicaid agency, itself*, "must conduct a preliminary investigation" of complaints of fraud and abuse "to determine whether there is sufficient bases to warrant a full investigation." *See* 42 C.F.R. § 455.14 [1999], Appendix at 98. If the findings of a preliminary investigation give the single state Medicaid agency reason to believe an incident of fraud or abuse has occurred involving a provider of Medicaid services, the *single state Medicaid agency* must refer the matter to the state Medicaid Fraud Control Unit for a full investigation. *See* 42 C.F.R. § 455.15 [1999], Appendix at 98.

The *single state Medicaid agency* may withhold Medicaid payments from a provider upon receipt of reliable evidence that the circumstances giving rise to the need for withholding payment involves fraud or wilful misrepresentation under the Medicaid program. 42 C.F.R. § 455.23 [1999], Appendix at 99-100. However, the affected provider must be given some notice of the withholding and the withholding may only be temporary. *Id.*

C. CALIFORNIA'S IMPLEMENTATION OF THE GOVERNING MEDICAID STATE PLAN REQUIREMENTS

The California State Medicaid Plan designates the California Department of Health Services ("State DHS") as the single state agency responsible for administering or supervising the administration of California's Medicaid program, which is known as "Medi-Cal." *See* Ninth Circuit Slip Opinion, Appendix at 8.

Prior to December 17, 1999, the California State Medicaid Plan specified that State DHS, the single state Medicaid agency, conducted reviews and investigations of Medicaid providers exclusively through State DHS' Audits and Investigations Division.

However, on December 17, 1999, State DHS submitted to U.S. DHHS a state plan amendment, which provided for the first time, that the California State Controller's Office ("State Controller") would also be performing audits of Medicaid expenditures on behalf of State DHS. The U.S. DHHS approved the plan amendment that very same day, December 17, 1999, and, pursuant to the request of State DHS, made the effective date of the Plan Amendment July 1, 1998. *See* letters transmitting the State Plan Amendment, Appendix at 101-108.

Even though the State Medicaid Plan had always expressly specified that only State DHS performed audits and investigations (*i.e.*, postpayment reviews) of Medicaid providers, State DHS had delegated some audit responsibility to the State Controller prior to the December 17, 1999, State Plan Amendment pursuant to a state "interagency agreement," dated July 1, 1997. The state interagency agreement was amended on July 1, 1998, to continue to allow the State Controller to conduct audits of providers on behalf of State DHS but prohibited the State Controller from unilaterally withholding payments from a provider and from furnishing its findings to law enforcement agencies. Instead, the State Controller was to furnish its audit findings directly to State DHS for further action.

STATEMENT OF THE CASE

A. STATEMENT OF THE FACTS

During 1998, and in some cases *prior to July 1, 1998*, the State Controller conducted separate postpayment reviews, *i.e.*, audits and investigations, of each petitioner's Medicaid claims. Based exclusively on the State Controller's audit findings, State DHS placed "temporary" withholds on 100% of the Medi-Cal payments of petitioner San Lazaro and petitioner Clinical Care. Based on joint findings of the State Controller's audit and investigation by the Federal Bureau of Investigation ("FBI"), State DHS also placed temporary withholds on 100% of the Medi-Cal payments owing to the separate pharmacy businesses operated by petitioners Nagapetyan and Simonyan. Appendix at 9-10.

It must be emphasized that the State Controller's audits and investigations of providers are not strictly financial but rather involve reviews and interpretations of patients' medical records, interviews with patients, and interviews with the patients' physicians. In any event, the State Controller's audit reports accused each petitioner of engaging in fraud or making wilful misrepresentations. These findings purportedly therefore enabled State DHS to impose temporary withholds on the Medicaid payments of the petitioners pursuant to 42 C.F.R. Section 455.23.[2]

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[2] The "temporary" withholds have never been lifted by State DHS and thus remain in effect for all Petitioners even though fraud proceedings were only initiated against two of the four separate Petitioners, Mr. Simonyan and Mr. Nagapetyan.

B. THE COURSE OF THE PROCEEDINGS BELOW

Petitioners San Lazaro and Clinical Care filed separate actions under 42 U.S.C. Section 1983 seeking to enjoin State DHS from using the Controller's audit and investigation findings to withhold their Medicaid payments arguing that the controlling federal Medicaid laws and regulations prohibited postpayment reviews by the State Controller. Petitioners Nagapetyan and Simonyan filed a joint action to prohibit State DHS from utilizing the Controller's audit and/or the FBI investigation findings to withhold their payments. The United States District Court, ruling on cross-motions for summary judgment, granted petitioners the relief they requested. The District Court enjoined State DHS from utilizing the Controller's audits to withhold Medicaid payments from petitioners. Ninth Circuit Slip Op., Appendix at 11-12.

The District Court concluded that: (1) by authorizing the State Controller to conduct Medi-Cal provider audits, State DHS improperly delegated its discretionary authority to the State Controller in violation of the single state Medicaid agency requirement; (2) petitioners, as Medi-Cal providers, had a right under 42 U.S.C. Section 1983 to enforce the single state agency requirement; and (3) the State Controller's audits could not constitute "reliable evidence" sufficient to justify withholding payments under 42 C.F.R. Section 455.23. The District Court also awarded petitioners attorneys fees under 42 U.S.C. Section 1988. Ninth Cir. Slip Op., Appendix at 11-12.

State DHS and the State Controller appealed these determinations to the Ninth Circuit, which consolidated the cases for hearing. Because San Lazaro had canceled its

laboratory license, the Ninth Circuit concluded that its claims had become moot and therefore dismissed State DHS' appeal regarding San Lazaro, except for the appeal of the District Court's order granting San Lazaro attorneys fees. However, the Ninth Circuit concluded that the other petitioners' claims presented live controversies over which it had jurisdiction.

With respect to the merits, the Ninth Circuit concluded that petitioners were not the intended beneficiaries of the requirements of the Medicaid single state agency law and regulations and therefore could not maintain a cause of action against State DHS or the State Controller under the Civil Rights Act to enforce those requirements in federal court. Moreover, the Ninth Circuit held that plaintiffs Nagapetyan and Simonyan could not assert viable claims for relief under 42 C.F.R. Section 455.23. Thus, the Ninth Circuit reversed the District Court's summary judgments and also therefore reversed the attorneys fees awards.

Petitioners timely filed a Petition for a Panel Rehearing and Suggestion for Rehearing En Banc with the Ninth Circuit. Petitioners contended that the Panel Decision directly conflicted with an existing opinion of the California Court of Appeal regarding the interpretation of the federal Medicaid single state agency requirement and emphasized that independent of the single state Medicaid agency requirement, the federal Medicaid provisions of 42 U.S.C. Section 1396a(a)(37) and 42 C.F.R. Section 447.45 entitle Medicaid providers to prompt payment subject only to prepayment and postpayment reviews by the single state Medicaid agency. Petitioners also asserted that they could enforce the provisions of the governing federal Medicaid laws and regulations under the Supremacy

Clause without respect to whether they were the intended beneficiaries of the applicable Medicaid statutes and regulations. The Ninth Circuit denied the Petition for Rehearing and Suggestion for Rehearing En Banc on April 17, 2002.

REASONS FOR GRANTING THE WRIT

A. THE IMPORTANCE OF THE ISSUES PRESENTED BY PETITIONERS

In its amicus curiae brief filed in the Court of Appeals, the U.S. DHHS characterized these as "significant cases regarding the administration of the Medicaid program and are ones of first impression in the Court of Appeals." U.S. DHHS Amicus Curiae Brief, pp. 1-2. U.S. DHHS asserted that "federal rights should not be conferred on Medicaid providers," which would unduly constrain the ability of the "states to combat waste, fraud and abuse by Medicaid providers." Amicus Curiae Brief, p. 2.

The California Court of Appeal, on the other hand, in *Doctor's Medical Laboratory, Inc. v. Connell*, 69 Cal.App.4th 891 (1999), Appendix at 109-117, pointed out why it is important for Medicaid providers to be able to enforce the governing Medicaid rules that require the single state Medicaid agency to perform Medicaid audits emphasizing:

> First, such [federal Medicaid] rules, if adhered to, avoid the delay entailed when several state agencies in succession review claims before payment is made. Here, DHS' agent, EDS, approved the claims, but then the Controller held them up. Second, the [federal Medicaid] rules offer a

> degree of assurance that state agencies reviewing provider claims will have knowledge and expertise concerning medical expense claims and the peculiar rules and regulations which govern Medicaid claims. By contrast, a nonspecialized agency such as the Controller, newly embarked on the business of reviewing medical provider claims, might well lack the expertise needed for prompt, fair review."

69 Cal.App.4th at 897, Appendix at 116.

The impact of the State Controller's Medicaid audits is not limited to a few, isolated providers in California. Indeed, after the decision in *Doctor's Medical Laboratory* prohibiting the State Controller from auditing and investigating Medicaid providers became final, State DHS in May 1999 imposed a blanket withhold on more than 100 different Medicaid providers whose Medicaid payments had been previously withheld based on audits by the State Controller. Also, as both State DHS and U.S. DHHS have previously pointed out, the single state Medicaid agencies in other states use "outside" agencies to conduct Medicaid audits and investigations.

The circumstances of the petitioners in these consolidated cases also demonstrate why review is necessary to protect the rule of law. Even though State DHS and the State Controller could ask Congress or the U.S. DHHS to amend the existing Medicaid laws or Medicaid regulations to permit agencies other than the single state Medicaid agencies to perform postpayment Medicaid claims reviews, they have not done so. Rather than doing so, they simply ignored the plain language of the applicable statutes and regulations and changed the provisions of the California State Medicaid Plan. They also ignored the controlling

federal Medicaid principles by adopting the findings of the State Controller based on an audit conducted prior to July 1, 1998, the effective date of the State Plan Amendment.

While State DHS and the State Controller will no doubt respond to these facts by pointing out that two of the petitioners, Nagapetyan and Simonyan, were ultimately convicted of Medicaid fraud, these "ends" do not justify the "means." Moreover, as emphasized in footnote 2, no fraud action was ever initiated against the other two petitioners, San Lazaro and Clinical Care. Yet, the untested allegations of the State Controller caused State DHS to withhold all Medicaid payments to San Lazaro and Clinical Care, which, in turn, shortly forced them out of business.

It is obvious that if Medicaid providers who are victimized by the State Controller's audits and investigations are not given the right to enforce the federal laws and regulations protecting them from improper Medicaid audit activities, no one else will enforce them. Therefore, even though the controlling federal Medicaid principles require the single state Medicaid agency to protect the legal rights of providers and to afford providers due process of the law in connection with actions, such as those undertaken here, unless the holding in this case is reversed, providers will be deprived of access to the federal courts to enforce these rights, rendering them meaningless.[3]

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[3] The active enforcement of health care antifraud and abuse measures is obviously necessary to protect the fiscal integrity of the Medicaid program. The controlling Medicaid statutes and regulations have specific mechanisms to be used for monitoring Medicaid expenditures and protecting against suspected cases of fraud and abuse. Those

(Continued on following page)

B. THE DECISION DIRECTLY CONFLICTS WITH THE DECISION OF THE CALIFORNIA COURT OF APPEAL IN *DOCTOR'S MEDICAL LABORATORY*

To support its decision that Medicaid providers are not intended beneficiaries of the Medicaid single state agency requirement, the Court of Appeals cited the California Court of Appeal decision in *RCJ Medical Services, Inc. v. Bonta*, 91 Cal.App.4th 986 (2001). In *RCJ*, the California Court of Appeal held that the Medicaid single state agency requirements of 42 C.F.R. Section 431.10(e) do not prohibit the single state Medicaid agency from delegating postpayment audit and review authority to the State Controller.[4]

However, the Court of Appeals in the instant case completely ignored the significant fact that in *Doctor's Medical Laboratory, Inc.*, the very same California Court of Appeal (but a different division of judges) expressly held that the governing federal Medicaid regulation, 42 C.F.R. § 431.10(e), prohibited State DHS from delegating postpayment review authority to the State Controller. According to the California Court of Appeal in *Doctor's*, "federal

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agencies and officials designated to enforce those mechanisms are perfectly capable of fulfilling their responsibilities in a manner that not only protects the rights of the taxpayers, but also protects the rights of Medicaid beneficiaries and providers of Medicaid services. If other federal and state agencies wish to pursue their own health care fraud enforcement agenda, they must do so pursuant to their own independent authority. For example, the State Controller and the FBI should not be allowed to conduct criminal investigations through the regulatory audit processes of the federal Medicaid laws and regulations. Yet, this is precisely what they did here with Petitioners Nagapetyan and Simonyan.

[4] RCJ Medical Services, Inc.'s Petition for Certiorari, Docket No. 01-1274, was denied by this Court on May 28, 2002.

Medicaid law barred" State DHS from delegating such authority to the State Controller. *See* 69 Cal.App.4th at 893, Appendix at 109. *See also* 69 Cal.App.4th at 897, in which the California Court of Appeal states that the "controller could not lawfully exercise power to audit provider payments and withhold alleged excesses." Appendix at 115.

Also, as pointed out above, the California Court of Appeal in *Doctor's* interpreted the controlling federal Medicaid regulation as benefitting providers, at least in part, by assuring that their Medicaid claims are not subjected to multiple-agencies' reviews and assuring that the state agencies reviewing Medicaid provider claims have knowledge and expertise concerning the claims.[5]

Unlike the *Doctor's* case, the California Court of Appeal in *RCJ* did *not* abide by the plain language of the controlling federal Medicaid regulation. Instead, the Court of Appeal in *RCJ* rewrote the language of the controlling regulation by "interpreting" the phrase from 42 C.F.R. Section 431.10(e) that the single state agency "must not delegate" the exercise of administrative discretion to mean

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[5] In fact, in a subsequent decision by the same California Court of Appeal in the same case, the Court expressly concluded that the federal Medicaid regulation prohibiting the single state agency from delegating discretionary decision-making to another state agency, 42 C.F.R. § 431.10(e), was intended "to benefit providers." *See* unpublished decision of the California Court of Appeal in *Doctor's Medical Laboratory v. Connell*, No. B134090, June 28, 2000, Slip Op. at p. 12, which opinion was appended to each of the appellate briefs filed by petitioners in the Court of Appeals here and should have been considered for its collateral estoppel effect.

that the single state agency "may delegate" such authority to other agencies.[6]

C. THE COURT OF APPEALS' DECISION INDIRECTLY CONFLICTS WITH THE REASONING OF THIS COURT AS WELL AS LOWER COURTS

1. The Court Should Not Have Limited Its Analysis To The Single State Agency Requirement In Determining Whether Petitioners May Use The Civil Rights Act To Enforce The Applicable Provisions Of The Medicaid Statutes And Regulations.

In determining whether petitioners could maintain their actions under the Civil Rights Act, 42 U.S.C. § 1983, the Court of Appeals erroneously confined its analysis to the single state agency requirement, 42 C.F.R. § 431.10, and its enabling statute, 42 U.S.C. § 1396a(a)(5), only.

The District Court, on the other hand, did not limit its analysis to the single state agency requirement. Rather, relying on its earlier decision in *Health Line Clinical Laboratory, Inc, et al. v. Connell, etc.,* District Court Case

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[6] The California Court of Appeal did so solely because of the interpretation given to the language of the regulation by U.S. DHHS in its December 17, 1999 approval of State DHS' state plan amendment permitting the State Controller to conduct audits and investigations of Medicaid providers on behalf of State DHS. However, the plain language of an agency regulation is controlling on both a reviewing court and the agency itself. *See United States ex rel. Rahman v. Oncology Associates, Inc.*, 198 F.2d 502, 514 (4th Cir. 1999), holding that the U.S. DHHS is not excused from complying with its own federal regulations just because it believes the language of the regulations is not in the public interest.

No. CV-98-1620-RJK (April 9, 1998), Appendix at 118-133, it carefully analyzed certain related federal Medicaid requirements relevant to the issue before the Court, including, 42 C.F.R. Section 455.13 and 42 C.F.R. Section 455.23. After discussing the application of these regulations to the Medicaid withholding actions imposed on petitioners, the District Court concluded that "these regulations were undoubtedly intended to benefit plaintiffs, and not merely to promote the efficient administration of the state plan." *Health Line* Slip Op., p. 7, Appendix at 125.

This Court and lower courts have held that a reviewing court must analyze the entire statutory scheme, including implementing agency regulations, to determine whether a plaintiff is an intended beneficiary for purposes of maintaining a cause of action under the Civil Rights Act. *See, for example, Wright v. Roanoke Redevelopment and Housing*, 479 U.S. 418, 427 (1987) [agency regulation confirmed that public housing tenants were intended beneficiaries of procedural requirements.] *See also Buckley v. City of Redding, Cal.*, 66 F.3d 188, 190, 192 (9th Cir. 1995) [agency's regulations construed to benefit plaintiffs] and *South Camden Citizens v. N.J. Dept. of Env. Prot.*, 145 F.Supp. 2d 505, 535-539 (D.N.J. 2001) [plaintiffs found to be intended beneficiaries of EPA regulations]. [7]

Here, while it is certainly true that the single state agency requirement, in isolation, could reasonably be

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[7] In those situations where this Court has decided that the plaintiffs are not the intended beneficiaries of a particular statutory scheme, it has done so only after exhaustively reviewing the *entire* statutory scheme, rather than simply analyzing one isolated provision. *See Pennhurst State Sch. & Hospital v. Halderman*, 451 U.S. 1 (1981).

interpreted as being intended primarily to facilitate federal oversight of the state Medicaid programs, when the requirement is read in the context of the other relevant statutory and regulatory state plan requirements, including 42 C.F.R. Sections 455.13 and 455.23, it becomes obvious that Medicaid providers are, in fact, intended beneficiaries of the critical requirement that postpayment review authority and investigatory authority may not be delegated by State DHS to another state agency.

When the provisions of Sections 455.13, 455.23 and 431.10(e) are read together, as they must be, it becomes clear that only the single state Medicaid agency, itself, may perform postpayment reviews. It may not delegate such responsibility to another agency. Indeed, there is no express statutory or regulatory provision allowing single state Medicaid agencies to delegate postpayment review authority or the authority to conduct investigations of Medicaid providers to other agencies, with the exception of 42 C.F.R. Section 455.15, which expressly requires the single state Medicaid agency to refer cases of suspected provider fraud to the State Medicaid Fraud Control Unit following the single state Medicaid agency's preliminary investigation of such alleged fraud. [8]

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[8] Ironically, in these cases, the only two agencies that should have been involved in the process – the single state Medicaid agency and the State Medicaid Fraud Control Unit, were not actively involved. Rather, the State Controller and the FBI were "calling the shots." In fact, the record is quite clear that the FBI used the regulatory procedures of 42 C.F.R. § 455.23 to further their criminal investigations of petitioners' Nagapetyan and Simonyan. *See, for example*, the FBI's February 2, 1999 letter to State DHS instructing State DHS to withhold Medicaid payments from 91 providers, including petitioners Nagapetyan and

(Continued on following page)

As indicated above, the Court in this case limited its analysis to the single state agency requirement, concluding that it was intended to facilitate federal oversight of state Medicaid programs. Slip Op., Appendix at 20.

This Court has previously held that simply because a particular provision of the Medicaid statutes and regulations facilitates federal oversight of the state Medicaid programs does *not* mean that providers are also not intended beneficiaries. *See Wilder v. Virginia Hosp. Ass'n.*, *supra*, in which this Court rejected the argument that providers should not be construed as the beneficiaries of the payment requirements of the "Boren Amendment" because those requirements were intended only to ensure that U.S. DHHS provide adequate oversight. Indeed, all of the state plan requirements of 42 U.S.C. Section 1396a are intended to facilitate the federal government's oversight of the state's administration of the Medicaid program. This is precisely why they are required to be included in a state plan, which must be reviewed and approved by the U.S. DHHS.

In this regard, it is important to note that Congress has specifically stated that in an action to enforce a provision of the Social Security Act, of which the Medicaid Act is a part, the provision is not to be deemed unenforceable because of its inclusion in a section of the Act requiring a state plan or specifying the required contents of a state plan. *See* 42 U.S.C. § 1320a-10. Yet, the Ninth Circuit has so construed the single state agency requirement, characterizing it as nothing more than a "structural

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Simonyan, based on the coordinated efforts of the State Controller and the FBI.

programmatic requirement that facilitates federal oversight of the state Medicaid programs." Ninth Circuit Slip Op., Appendix at 20.

Before leaving this topic, it must also be pointed out that independent of the single state agency requirements, providers must be construed to be intended beneficiaries of those separate federal requirements governing the effective date of state plan amendments. As indicated above, material changes in the organization and functions of the single state Medicaid agency must be implemented through state plan amendments. *See* 42 C.F.R. § 430.12(c)(1)(ii), Appendix at 86. In fact, this is precisely why State DHS submitted to the U.S. DHHS the December 17, 1999 State Plan Amendment since it was not until State DHS submitted the Plan Amendment to the federal government and the federal government approved the Plan Amendment that the State Medicaid Plan specified that audits are conducted by the State Controller's Office.

Yet, while State DHS arguably cured an important procedural defect by amending its State Medicaid Plan, State DHS nevertheless relied on the audit findings of the State Controller in this case even when those audit findings were issued prior to July 1, 1998, the retroactive effective date of the December 17, 1999 State Plan Amendment. Thus, for example, even though the State Controller completed its audit of Simonyan's Medicaid business in May 1998, the state relied on those findings (at least in part) as a basis for withholding Mr. Simonyan's payments.

Such action violated the federal Medicaid regulation regarding the impact and effective date of plan amendments, which is obviously intended to benefit all participants in the Medicaid program, including providers. *See, for example, Exeter Memorial Hospital Association v. Belshe*, 145 F.3d 1106, 1109 (9th Cir. 1998) [State DHS' action prohibited from being implemented prior to the effective date of a state plan amendment] and *Oregon Association of Home v. State Dept. of Human Services*, 5 F.3d 1239 (9th Cir. 1993) [state Medicaid policy invalid because it was not submitted as a plan amendment to the federal government].

2. Even If Petitioners Are Not The Intended Beneficiaries Of The Federal Medicaid Requirements At Issue, They May Enforce Them In Federal Court Under The Supremacy Clause Of The United States Constitution

Although petitioners specifically brought the Supremacy Clause issue to the attention of the Court of Appeals, the Court of Appeals' decision does not address the issue. This omission is very important since petitioners had the right, independent of any statutory right under 42 U.S.C. Section 1983, to enforce the provisions of the Medicaid law under the Supremacy Clause of the Constitution pursuant to a federal preemption argument. Specifically, the *state* interagency agreement between State DHS and the State Controller pursuant to which the State Controller, had been conducting Medicaid audits, including the audits, was preempted (both expressly and impliedly) by the

provisions of the *federal* Medicaid statutes and regulations, which required State DHS, itself, to conduct audits and investigations of the claims of Medicaid providers.

In a relatively recent decision of the Court of Appeals for the First Circuit, *Pharmaceutical Research and Mfrs. v. Concannon*, 249 F.3d 66 (1st Cir. 2001), the Court held that the provisions of the federal Medicaid laws and regulations could expressly or impliedly preempt state law and state policy under the Supremacy Clause of the United States Constitution. As a result, the First Circuit concluded that a manufacturer of pharmaceuticals could maintain a cause of action challenging a state Medicaid agency's authority under a preemption-based argument under the Supremacy Clause even if the manufacturer was not an intended beneficiary of the federal Medicaid law, itself. 249 F.3d at 73-74 ["it is the interests protected by the supremacy clause, not by the preempting statute, that are at issue here"]. In other words, the petitioners' rights under the Supremacy Clause exist independent of any right to maintain an action under the federal Medicaid laws and regulations, themselves. *See* 249 F.3d at 73, where the Court clarifies that regardless of whether the Medicaid statute's relevant provisions were designed to protect the plaintiff in that case, it could invoke the statute's preemptive force under the Supremacy Clause.[9]

Similarly, in *Duke Energy Trading & Marketing, L.L.C. v. Davis*, 267 F.3d 1042 (9th Cir. 2001), the United

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[9] Recently, the Sixth Circuit has afforded prudential standing rights to two professional organizations to enforce certain Medicaid provisions because their members alleged injury-in-fact caused by State Medicaid officials. *See Westlake Mothers v. Haveman*, 2002 W.L. 987291 (6th Cir.)

States Court of Appeals for the Ninth Circuit held that a plaintiff could maintain an action to enjoin state officials from violating federal law based on the Supremacy Clause of the United States Constitution even if such an action did not exist under the federal statute, itself. 267 F.3d at 1055. While *Duke* did not involve the federal Medicaid program, it involved a similar federal statute, which, like the Medicaid laws here, also precluded inconsistent state regulatory actions.

In this case, the combination of the federal Medicaid statutes and regulations which prohibit the single state Medicaid agency from delegating postpayment review, audit, and investigation responsibilities to another agency (at least until the State Medicaid Plan is amended to purportedly permit such delegation) preempted the state interagency agreement, pursuant to which the State Controller was acting when it audited the claims of the petitioners. Because of the supremacy of the federal Medicaid laws and regulations, the *state* interagency agreement was therefore preempted to the extent it purported to allow State DHS to delegate such authority to another state agency.

Thus, independently of any right that might exist to maintain an action under the federal Medicaid laws and regulations, petitioners have the right to maintain these actions in federal court under the Supremacy Clause of the United States Constitution.

CONCLUSION

Based on the foregoing, the Court is respectfully requested to grant the Petition for Writ of Certiorari to decide the two important questions of law raised by this Petition.

Dated: June 25, 2002

Respectfully submitted,

PATRIC HOOPER
HOOPER, LUNDY & BOOKMAN, INC.

Attorneys for Petitioners

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

SAN LAZARO ASSOCIATION, INC., dba Biomedical Laboratory, *Plaintiff-Appellee,* v. KATHLEEN CONNELL, Controller of the State of California, *Defendant-Appellant.*	Nos. 00-55065 00-55610 D.C. No. CV-98-06216-RJK
OGANES NAGAPETYAN; KHACHIK SIMONYAN, *Plaintiffs-Appellees,* v. KATHLEEN CONNELL, Controller of the State of California; JOSEPH MUNSO [sic], Chief Deputy Director of the California Department of Health Services, *Defendants-Appellants.*	No. 00-55377 D.C. No. CV-99-02420-RJK
CLINICAL CARE LABORATORY, INC., *Plaintiff-Appellee,* v. KATHLEEN CONNELL, Controller of the State of California; S. KIMBERLY BELSHE, Director of the Department of Health Services, *Defendants-Appellants.*	No. 00-55963 D.C. No. CV-98-08425-RJK ORDER AND AMENDED OPINION

SAN LAZARO ASSN v. CONNELL

Appeal from the United States District Court
for the Central District of California
Robert J. Kelleher, District Court Judge, Presiding

Argued and Submitted
July 10, 2001 – Pasadena, California

Filed January 24, 2002
Amended April 17, 2002

Before: John T. Noonan, Barry G. Silverman, and Richard A. Paez, Circuit Judges.

Opinion by Judge Paez

COUNSEL

Sandra L. Goldsmith, Deputy Attorney General of the State of California, Los Angeles, California, for the defendants-appellants.

Patric Hooper, Hooper, Lundy & Bookman, Inc., Los Angeles, California, for the plaintiffs-appellees.

Robert D. Kamenshine, United States Department of Justice, Civil Division, Washington, D.C., for amicus United States Department of Health and Human Services, in support of defendants-appellants.

ORDER

The panel has unanimously voted to deny the petition for rehearing. The full court has been advised of the petition for rehearing en banc, and no active judge of the court has requested a vote on the petition for rehearing en

banc. Fed. R. App. P. 35(b). The petition for rehearing is denied and the petition for rehearing en banc is denied.

The opinion filed January 24, 2002, is hereby AMENDED as follows:

1. On page 1081 of the slip opinion, the text beginning "The plaintiffs relied on statutory provisions" and ending "federal guidelines. *Id.*" is deleted. The following new paragraph is inserted: "The Court noted that the plaintiffs in *Blessing* had not "identif[ied] with particularity the rights they claimed," and went on to note that some of the provisions of Title IV-D were systemic or structural. *Id.* at 342-44. For example, Title IV-D provides that States, if they are to receive federal funds, must include, *inter alia*, a "comprehensive system to establish paternity, locate absent parents, and help families obtain support orders." *Id.* at 333-34. The statute at issue in *Blessing* also provides specific guidelines for the "structure" of the state agency designated to administer this system, such as a requirement for sufficient staffing levels. *Id.* at 333-35. Additionally, Title IV-D contains the more general requirement that state AFDC plans must be in "substantial compliance" with these and other federal guidelines. *Id.*"

2. On page 1082, delete the phrase "but, with respect to the particular "systemwide" requirements that the plaintiffs invoked" and insert "but, with respect to the "systemwide" requirements in Title IV-D". After "*Id.* at 344" and before "The structural requirements" the following footnote 9 is inserted:

   "While spelling out that the systemic and structural provisions of Title IV-D do not give rise to rights enforceable under § 1983, *Blessing* did "not foreclose the possibility that some provisions of Title IV-D give rise to individual rights," and remanded for the District

Court to construe the complaint to determine whether "any specific claim asserts an individual federal right." *Id.* at 345-346."

OPINION

PAEZ, Circuit Judge:

This case arises from a joint effort by the State of California and the Federal Bureau of Investigation ("FBI") to investigate fraud in the State's Medicaid/Medi-Cal Program. Plaintiffs are providers of medical services to Medi-Cal recipients. The California Department of Health Services ("DHS") instructed the Controller of the State of California ("Controller") to withhold payments to Plaintiffs after receiving an audit report from the Controller and other information from the FBI that Plaintiffs may have submitted fraudulent payment requests. Plaintiffs, in three separate actions under 42 U.S.C. § 1983, sought to enjoin DHS from utilizing the Controller's audit and the FBI information to withhold payments. The district court, ruling on cross-motions for summary judgment, granted Plaintiffs the relief they requested. It enjoined DHS from utilizing the Controller's audits to withhold payments to Plaintiffs. The district court concluded that: (1) by authorizing the Controller to conduct Medi-Cal provider audits, DHS improperly delegated its discretionary authority to the Controller in violation of a requirement under the Medicaid Act[1] that a single state agency administer or supervise the State's Medicaid program; (2) Plaintiffs, as Medi-Cal providers, had a right under 42 U.S.C. § 1983 to

[1] See Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-96v, and 42 C.F.R. § 431.10(e).

enforce the single state agency requirement; and (3) the Controller's audit could not constitute "reliable evidence" sufficient to justify withholding payments under 42 C.F.R. § 455.23. The district court also awarded Plaintiffs attorney's fees under 42 U.S.C. § 1988.

Because there have been significant developments regarding the status of several of the Plaintiffs as Medi-Cal providers during the course of the district court proceedings as well as after entry of the district court's judgments, we initially address whether any of Plaintiffs' claims are moot. We conclude that, because Plaintiff San Lazaro Association, Inc. ("San Lazaro") canceled its laboratory license, its claims are moot. Accordingly, we dismiss the appeal in case no. 00-55065. Nonetheless, we have jurisdiction over Defendants' appeal in case no. 00-55610 from the district court's order granting San Lazaro attorney's fees. Aside from San Lazaro's claims, the other Plaintiffs' claims present live controversies over which we have jurisdiction. We also have jurisdiction over Defendants' appeals from the district court's orders granting attorney's fees to these Plaintiffs.

On the merits, because we hold that the single state agency requirement does not establish a right that the remaining Plaintiffs can enforce under 42 U.S.C. § 1983, we reverse the district court's summary judgments. We also reverse the attorney's fee awards under 42 U.S.C. § 1988. Finally, we hold that Plaintiffs Nagapetyan and Simonyan cannot assert a viable claim for relief under 42 C.F.R. § 455.23.

I.

Background

We briefly review the structure of the Medicaid Act and its implementation in California. We also summarize the events that precipitated the instant actions, and the district court's resolution of Plaintiffs' claims.

A. *Medicaid and Medi-Cal*

Under the Medicaid Act, the federal government underwrites part of the costs of state programs providing medical care to eligible needy individuals. In order to receive federal support, the States must comply with requirements of the Medicaid Act and with regulations promulgated by the Department of Health and Human Services ("HHS"). *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

1. *Single state agency requirement*

Among the requirements that the Medicaid Act established for state programs, 42 U.S.C. § 1396a(a)(5) mandates that a participating State "provide for the establishment or designation of a single State agency to administer or to supervise the administration of the [State's] plan." HHS' regulations interpret this requirement as follows:

> [ ] Authority of the single State agency. In order for an agency to qualify as the Medicaid agency –
>
> (1) The agency must not delegate, to other than its own officials, authority to –

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

42 C.F.R. § 431.10(e).

2. *Payment and verification of provider claims*

Under the Medicaid Act, "[t]he state plan is required to establish . . . a scheme for reimbursing health care providers for the medical services provided to needy individuals." *Wilder*, 496 U.S. at 502. Various statutory provisions and regulations require the States to verify the legitimacy of payment claims. *See, e.g.*, 42 U.S.C. § 1396a(a)(42) (explaining that a state plan must "provide that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as . . . necessary to insure that proper payments are made under the plan"); 42 C.F.R. § 447.202 ("The Medicaid agency must assure appropriate audit of

records if payment is based on costs of services or on a fee plus costs of materials.").

A provider may face various consequences for submitting an improper claim. A state's Medicaid agency can withhold payments to providers "upon receipt of reliable evidence" that a provider has engaged in "fraud" or "willful misrepresentation." 42 C.F.R. § 455.23(a). Overpayments can be recovered through administrative proceedings. *See e.g.*, Cal. Code Regs. tit. 22, § 51047. Providers can be decertified and barred from participation in the Medicaid program. 42 U.S.C. § 1320a-7(a)(1) & (6). Medicaid fraud also may result in criminal prosecution. 42 U.S.C. § 1320a-7b(a) (setting forth criminal penalties for false statements or representations in provider claims for payments); 18 U.S.C. § 1347 (specifying criminal penalties for scheme to defraud health care benefit program); *see also United States v. Woodley*, 9 F.3d 774, 778 (9th Cir. 1993) (upholding mail fraud conviction against Medicare provider).

3. *California's Medicaid program*

Pursuant to 42 U.S.C. § 1396a(a)(5), California has designated DHS as its Medicaid agency, with responsibility for "administer[ing] or . . . supervis[ing] the administration" of Medi-Cal, California's Medicaid program.

DHS retains a private contractor, Electronic Data Services ("EDS"), to process reimbursement claims by Medi-Cal providers. EDS utilizes an electronic claims processing system to review Medi-Cal claims and determine the amount owed. EDS then forwards its calculations to the Controller for payment. However, EDS does not conduct audits of provider claims.

DHS audits some provider claims, and supplements its own efforts by relying on audits performed by the Controller. DHS has defined the scope of the Controller's audit responsibilities through a series of inter-agency agreements with the Controller. A number of other agencies also may become involved in Medi-Cal fraud investigations. At relevant times, for example, the FBI has worked with both DHS and the Controller to investigate Medi-Cal fraud.

B. *Investigations and proceedings involving Plaintiffs*

When the four Plaintiffs filed these actions, they were Medi-Cal providers. Khachik Simonyan was the owner of Eagle Medical Supply ("Eagle"), and Oganes Nagapetyan owned Nairi Pharmacy ("Nairi"). Both Eagle and Nairi provided medical supplies and equipment to Medi-Cal recipients. San Lazaro provided laboratory tests for Medi-Cal recipients. Clinical Care Laboratory, Inc. ("Clinical Care") provided clinical laboratory services to Medi-Cal recipients.

In 1998, the Controller audited all four Plaintiffs. In addition, the FBI, in coordination with the Controller, initiated an investigation of Eagle and Nairi. The investigations disclosed evidence of possible fraud. The Controller and the FBI reported their findings to DHS and either requested or recommended that DHS temporarily

withhold payments to all Plaintiffs.[2] DHS ultimately withheld payments to all four Plaintiffs.

C. *Legal proceedings*

1. *Nature of the claims*

Plaintiffs filed three separate lawsuits in federal district court. San Lazaro and Clinical Care filed separate actions in 1998. Simonyan and Nagapetyan jointly filed an action in 1999. In each case, Plaintiffs alleged that Medicaid's single state agency requirement prohibited DHS from delegating responsibility to the Controller for conducting provider audits and from relying on the results of the Controller's audits to withhold payments. Plaintiffs also alleged that, under the Medicaid Act, the Controller's audit findings could not be considered reliable evidence of fraud or willful misrepresentation. And they contended that DHS' improper delegation of responsibility was actionable under 42 U.S.C. § 1983. Plaintiffs sought declaratory relief that the Controller's audit activities were contrary to law, an injunction against further audits by the Controller, and an injunction against continued withholding of payments. All three related actions were assigned to the same district court judge.

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[2] Because providers are paid from the Treasury of the State of California and the Controller is responsible for making authorized payments from the Treasury, DHS, as the single state agency, must instruct the Controller to withhold payment. Accordingly, we refer to DHS as withholding the payments.

2. *Preliminary injunctive relief and summary judgment on the merits*

The district court granted preliminary injunctive relief in all three cases. Then, in three successive rulings, the district court granted summary judgment in favor of each Plaintiff.

The district court held that the alleged violations of Medicaid's single state agency requirement were actionable under § 1983. In concluding that Defendants had violated the single state agency requirement, the district court relied primarily on 42 C.F.R. § 431.10(e)(1)(i), which prohibits a State's designated Medicaid agency from delegating authority to "[e]xercise administrative discretion in the administration or supervision of the plan." The district court interpreted that provision to mean that no state agency other than California's Medicaid agency (DHS) could undertake any programmatic Medi-Cal task that requires any form of review or discretion. Concluding that the Controller's audits required review and discretionary analysis, the district court held that the audits violated 42 C.F.R. § 431.10 and could not be the basis for withholding payments to providers.[3]

The district court also ruled that DHS violated 42 C.F.R. § 455.23[4] when it failed to obtain "reliable evidence" of fraud before withholding payments. The district court

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[3] The district court suggested that DHS' reliance on investigative findings by the FBI also would involve an impermissible delegation of authority.

[4] Section 455.23 provides in relevant part: "The State Medicaid agency may withhold Medicaid payments . . . to a provider upon receipt of reliable evidence . . . [of] fraud or willful misrepresentation under the Medicaid program."

ultimately excluded from DHS's consideration any evidence from the Controller's audits, reasoning that the single state agency requirement prohibited the Controller from gathering evidence of fraud.

The district court granted Plaintiffs' motions for summary judgment and permanently enjoined the Controller and her agents from auditing, reviewing, or investigating Medi-Cal reimbursement claims by Plaintiffs. The district court also enjoined DHS from withholding Medi-Cal payments on the basis, either directly or indirectly, of the Controller's audits. Finding that each of the Plaintiffs were prevailing parties under 42 U.S.C. § 1988, the district court awarded each of them attorney's fees.

Defendants filed timely notices of appeal from the district court's orders and from its entry of judgment in each case.

II.

Mootness

Before addressing the merits, we must determine whether the issues presented to us on appeal have been rendered moot by intervening developments. *See Arizonans for Official English v. Arizona*, 520 U.S. 43, 66-67 (1997) (holding that mootness is jurisdictional); *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 94-95 (1998) (plurality opinion) (holding that jurisdictional questions must be addressed before merits); *id.* at 110-11 (O'Connor, J., concurring) (observing that "federal courts should be certain of their jurisdiction before reaching the merits of a case").

A case loses its quality as a "present, live controversy" and becomes moot when there can be no effective relief. *Cantrell v. City of Long Beach*, 241 F.3d 674, 678 (9th Cir. 2001). Here, because of the doctrine of sovereign immunity, Plaintiffs can seek only prospective, injunctive relief.[5] Thus, for Plaintiffs to have a live "case or controversy" with the State, they must be in a position to benefit from prospective, injunctive relief.

We conclude that San Lazaro's claim on the merits is moot. However, the other Plaintiffs' challenges to the Controller's audits and to DHS' reliance on those audits

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[5] Under *Ex Parte Young*, the district court could grant prospective injunctive relief against state officials, such as the Controller, to enjoin them from unlawful conduct. 209 U.S. 123, 155-156 (1908). The district court could not, however, award "retroactive payment of benefits found to have been wrongfully withheld" by state officials. *Edelman v. Jordan*, 415 U.S. 651, 678 (1974); *Id.* at 668-69 (holding that sovereign immunity bars relief that would "require [ ] payment of state funds, not as a necessary consequence of compliance in the future with a substantive federal-question determination, but as a form of compensation to those" who were harmed by a past legal wrong "at a time when [the State] was under no court-imposed obligation to conform to a different standard.").

These constraints would not apply if California consented to suit for retroactive damages. *Id.* at 673. But "[i]n deciding whether a State has waived its constitutional protection under the Eleventh Amendment, [courts] will find [a] waiver only where stated by the most express language or by such overwhelming implications from the text as (will) leave no room for any other reasonable construction." *Id.* (internal quotation marks and citation omitted). The States, including California, have not consented to suit by accepting Medicaid funds. *See Fla. Ass'n of Rehab. Facilities, Inc. v. Fla. Dep't of Health and Rehab. Servs.*, 225 F.3d 1208, 1226 n. 13 (11th Cir. 2000); *see also Wilder*, 496 U.S. at 516-518 (noting that provision in Medicaid statute requiring, as a condition of participation, waiver by the States of sovereign immunity was repealed in 1976, after which only "prospective, injunctive relief" was available).

present live controversies over which we have jurisdiction. We also have jurisdiction to review the district court's awards of attorney's fees to Plaintiffs.

A. *San Lazaro*

Shortly after the district court entered summary judgment, San Lazaro voluntarily canceled its laboratory license. By canceling its license, San Lazaro became ineligible to participate in the Medi-Cal program. *See* Cal. Bus. & Prof. Code § 1265(a); Cal. Code Regs. tit. 22, §§ 51200, 51211.2. Defendants then moved under Rule 60(b) of the Federal Rules of Civil Procedure to alter or amend the district court's order granting summary judgment, arguing that San Lazaro's claim had become moot. Because San Lazaro no longer could benefit from the injunctive relief the district court had granted, the district court agreed with Defendants, vacating its summary judgment and dismissing the case as moot.[6] The district court nonetheless awarded San Lazaro attorney's fees on the ground that San Lazaro was the prevailing party under 42 U.S.C. § 1988 because it had obtained injunctive relief that for a time altered the legal relationship between San Lazaro and Defendants.

We agree with the district court that San Lazaro's claims became moot when it canceled its laboratory license. *See City News & Novelty, Inc. v. City of Waukesha*, 531 U.S. 278, 283 (2001) (holding that challenge to adult

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[6] The Controller's appeal of the grant of summary judgment, filed before the district court vacated the summary judgment, is still pending as case no. 00-55065. We dismiss that appeal because the claims are now moot.

business licensing determination was moot where plaintiff "has ceased to operate as an adult business and no longer seeks to renew its license").[7] Although San Lazaro's substantive claims are moot, its entitlement to attorney's fees is not. *See Zucker v. Occidental Petroleum Corp.*, 192 F.3d 1323, 1329 (9th Cir. 1999) (holding that "[n]o Article III case or controversy is needed with regard to attorneys' fees as such, because they are but an ancillary matter" over which courts retain jurisdiction "even when the underlying case is moot").

B. *Simonyan and Nagapetyan*

There are no facts in the record that suggest that the dispute between Simonyan and Defendants is moot. With respect to Nagapetyan, after entry of the district court's judgment, he was convicted of Medi-Cal fraud, and as a result was disqualified from participating in the Medi-Cal program for at least five years. Defendants therefore argue that his case is moot. The district court concluded that Nagapetyan's claim was not moot, because he still might seek to participate in the Medi-Cal program at the expiration of the five-year period.

On the record before us, we have no basis for concluding that Nagapetyan will not seek to participate in the Medi-Cal program at the end of the five-year period or that he would be barred from participation at that time.

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[7] There are exceptions to the mootness doctrine, *Cole v. Oroville Union High Sch. Dist.*, 228 F.3d 1092, 1098 (9th Cir. 2000) (en banc), *cert. denied*, 121 S. Ct. 1228 (2001), but no party has argued that an exception applies in this case.

We therefore agree with the district court that Nagapetyan's claim is not moot. *See United States v. Concentrated Phosphate Exp. Ass'n*, 393 U.S. 199, 203 (1968) (holding that case may become moot "if subsequent events ma[ke] it *absolutely clear* that the allegedly wrongful behavior could not reasonably be expected to recur") (emphasis added). Also, independent of our conclusion that neither Simonyan's nor Nagapetyan's claims are moot, we have jurisdiction to hear Defendants' appeal from the district court's order granting attorney's fees to Simonyan and Nagapetyan.

C. *Clinical Care Laboratory*

After Clinical Care filed its complaint, it ceased its business operations and DHS canceled the licenses and certifications that Clinical Care needed to participate in the Medi-Cal program. Also, the Controller completed a final audit report concluding that Clinical Care had claimed payment for services it had not performed. In response to the final audit, Clinical Care requested an administrative hearing with DHS to challenge the audit and DHS's decision to withhold payments. The district court held that the case was not moot because Clinical Care could still seek to enjoin DHS from using the Controller's audits in those proceedings.

We agree with the district court that, because of the potential availability of such relief, Clinical Care's claims are not moot. And, independent of that conclusion, we have jurisdiction over the district court's order granting attorney's fees to Clinical Care.

III.

Merits

In a preliminary ruling that was essential to its ultimate judgment granting injunctive relief to Plaintiffs, the district court accepted Plaintiffs' argument that they have an enforceable right under § 1983 to have the Medi-Cal program administered in accordance with Medicaid's single state agency requirement. We disagree with the district court's determination, and therefore hold that Plaintiffs were not entitled to summary judgment.

"In order to seek redress through § 1983, . . . a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing v. Freestone*, 520 U.S. 329, 340 (1997) (emphasis in original). In *Blessing*, the Supreme Court summarized the approach charted by previous cases:

> We have traditionally looked at three factors when determining whether a particular statutory provision gives rise to a federal right. First, Congress must have intended that the provision in question benefit the plaintiff. [*Wright v. Roanoke Redev. & Hous. Auth.*, 479 U.S. 418, 430 (1987)]. Second, the plaintiff must demonstrate that the right assertedly protected by the statute is not so "vague and amorphous" that its enforcement would strain judicial competence. [Id. at 431-32]. Third, the statute must unambiguously impose a binding obligation on the States . . . [*Wilder*, 496

U.S. at 510-511; *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981).]

520 U.S. at 340-41.[8]

Unless Plaintiffs establish that they are the intended beneficiaries of 42 U.S.C. § 1396a(a)(5) and of the regulations interpreting that provision, they do not have an enforceable right, and cannot maintain an action, under § 1983. *Wilder*, 496 U.S. at 509 (The "inquiry turns on whether the provision in question was intended to benefit the putative plaintiff. If so, the provision creates an enforceable right unless it reflects merely a congressional preference for a certain kind of conduct rather than a binding obligation on the governmental unit, or unless the interest the plaintiff asserts is too vague and amorphous such that it is beyond the competence of the judiciary to enforce.") (internal quotation marks, citations and brackets omitted); *see also Wesley Health Care Ctr., Inc. v. DeBuono*, 244 F.3d 280, 283 (2d Cir. 2001) ("A plaintiff must show that the violation of the federal law also amounts to the violation of a federal right *possessed by the plaintiff*.") (emphasis added). In analyzing Plaintiffs' contention that they are the intended beneficiaries of the

[8] In addition, "[e]ven if a plaintiff demonstrates that a federal statute creates an individual right, there is only a rebuttable presumption that the right is enforceable under § 1983. Because our inquiry focuses on congressional intent, dismissal is proper if Congress specifically foreclosed a remedy under § 1983." *Blessing*, 520 U.S. at 341 (internal quotation and citation omitted). Because we conclude that Plaintiffs have not demonstrated that Medicaid providers have a right to have Medicaid programs administered in accordance with the single state agency requirement, we need not address this additional hurdle for § 1983 plaintiffs.

single state agency requirement, we find *Blessing*'s application of the "intended beneficiary" prong highly instructive.

In *Blessing*, the plaintiffs were mothers whose children were eligible for child support services under Arizona's Aid to Families with Dependent Children ("AFDC") program. The plaintiffs claimed that Arizona had not taken adequate steps to obtain child support payments from their childrens' fathers. *Blessing*, 520 U.S. at 337. They argued that Arizona's allegedly deficient performance violated various provisions of Title IV-D of the Social Security Act and that such violations were actionable under § 1983. *Id.*

The Court noted that the plaintiffs in *Blessing* had not "identif[ied] with particularity the rights they claimed," and went on to note that some of the provisions of Title IV-D were systemic or structural. *Id.* at 342-44. For example, Title IV-D provides that States, if they are to receive federal funds, must include, *inter alia*, a "comprehensive system to establish paternity, locate absent parents, and help families obtain support orders." *Id.* at 333-34. The statute at issue in *Blessing* also provides specific guidelines for the "structure" of the state agency designated to administer this system, such as a requirement for sufficient staffing levels. *Id.* at 333-35. Additionally, Title IV-D contains the more general requirement that state AFDC plans must be in "substantial compliance" with these and other federal guidelines. *Id.*

The Court concluded that the requirements on which the plaintiffs relied were "not intended to benefit individual children and custodial parents" and therefore did not create "individual entitlement[s]." *Id.* at 343. The Court

viewed provisions requiring "substantial compliance" and "sufficient staffing" as "designed only to guide the State in structuring its systemwide efforts at enforcing support obligations." *Id.* at 344-45. Obviously, state AFDC programs are intended to benefit dependent children and their supporting parents, but, with respect to the "systemwide" requirements in Title IV-D the Court noted that "[t]hese provisions may ultimately benefit individuals who are eligible for [AFDC] services, but only indirectly." *Id.* at 344.[9] The structural requirements were "simply intended to improve the overall efficiency of the States' child support enforcement scheme." *Id.* at 345.

Our analysis of Medicaid's single state agency requirement leads us to a similar conclusion. The text of 42 U.S.C. § 1396a(a)(5) and 42 C.F.R. § 431.10(e), along with the legislative and regulatory history, persuade us that the single state agency requirement is a structural programmatic requirement that facilitates federal oversight of state Medicaid programs.[10] *Blessing*, 520 U.S. at 344. It does not create "individual entitlement[s]." *Id.* at 343.

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[9] While spelling out that the systemic and structural provisions of Title IV-D do not give rise to rights enforceable under § 1983, *Blessing* did "not foreclose the possibility that some provisions of Title IV-D give rise to individual rights," and remanded for the District Court to construe the complaint to determine whether "any specific claim asserts an individual federal right." *Id.* at 345-346.

[10] We note that the California Court of Appeal has reached the same conclusion in an unrelated case involving the review of an administrative determination by DHS based on the Controller's finding of an overpayment to a Medi-Cal provider. *RCJ Med. Servs., Inc. v. Bonta*, 111 Cal. Rptr. 2d 223, 231-32, 238 (Ct. App. 2001). The state court of appeal deferred to HHS' opinion that DHS's delegation of audit authority to the Controller was consistent with the single state agency requirement. *Id.* at 235. The court stated that the purpose of that

(Continued on following page)

A. *Single state agency requirement*

1. *Statutory and regulatory scheme*

Neither the statute nor the regulations are phrased in terms that define a legal right possessed by providers, and neither "focus[es]" on providers. *Cf. Wilder*, 496 U.S. at 510, 527 ("There can be little doubt that health care providers are the intended beneficiaries of the Boren Amendment. The provision establishes a system for reimbursement of providers and is phrased in terms of benefiting . . . providers"); *Wright*, 479 U.S. at 430 (holding that where limitations on public housing rent levels "focus[ ] on the individual family and its income . . . [t]he intent to benefit tenants is undeniable"). To the contrary, the single state agency requirement mandates an administrative structure for state Medicaid programs. This administrative scheme imposes a "systemwide" requirement that administration and overall supervision of state Medicaid programs be centralized. The single state agency requirement allows Congress to specify how state Medicaid agencies must carry out their Medicaid functions, from providing benefits to Medicaid recipients to keeping statistics and reporting those statistics and other information to the federal government.

In short, although the single state agency requirement may "ultimately benefit" many of those who have dealings with state Medicaid programs, it cannot be said to do so in any targeted manner. *Blessing*, 520 U.S. at 344. To the

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requirement was "to avoid a diversity of operating standards within a state and to ensure that one agency would be accountable to the federal government for the operation of [the] Medicaid program and compliance with federal law." *Id.* at 238.

extent there is a benefit to such individuals, it is an indirect one. *Id.*

2. *Legislative history*

The legislative history of the single state agency requirement supports this conclusion. The requirement in the Medicaid Act is patterned after the single state agency requirement imposed on the States by the Social Security Act of 1935. *See* 42 U.S.C. §§ 302, 1202. Congress' purpose in including the requirement in the Social Security Act of 1935 is not entirely clear, but it suffices to note that nothing in the legislative history of the Social Security Act suggests that the single state agency requirement was included for the benefit of providers of services.[11]

Congress included a parallel single state agency requirement in the Medicaid Act in 1965 without significant discussion. The only debate was whether the Medicaid Act should require a particular type of state agency to serve as the single state agency or instead whether States should be permitted to designate an agency of their choice.

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[11] Prior to enactment of the Social Security Act of 1935, most social welfare benefits were provided at the county level. One of the arguments for enacting federal social security legislation was that Congress should eliminate disparities in benefit levels and eligibility criteria among local jurisdictions. Robert B. Stevens, *Statutory History of the United States: Income Security* 20-31, 70-81 (1970) (quoting from *Social Security in America*, a report of the Commission on Economic Security). And at least one explanation for Congress's inclusion of the single state agency requirement in the Social Security Act is that the requirement was intended to "avoid a diversity of operating standards in the subdivisions within the State[s]." *Guidice v. Jackson*, 726 F. Supp. 632, 635 (E.D. Va. 1989) (quoting Social Security Board, *Social Security in America, A Summary of the Staff Reports of the Committee on Economic Security* 161, 191 (1937)), *aff'd*, 915 F.2d 1564 (4th Cir. 1990).

See Sobky v. Smoley, 855 F. Supp. 1123, 1145-46 (E.D. Cal. 1994) (reviewing legislative history). Nothing in the legislative history of the Medicaid Act ties the single state agency requirement to the interests of providers.

3. *History of agency interpretation*

The history of 42 C.F.R. § 431.10, the regulation interpreting the Medicaid Act's single state agency requirement, is more illuminating in identifying the purpose of the requirement, but is of no help to Plaintiffs. That history suggests that the single state agency requirement was intended primarily to ensure systemwide accountability of state Medicaid programs to the federal government. And, more to the point, that history provides no evidence that the requirement was intended to benefit Medicaid providers.

Prior to the 1965 enactment of the Medicaid Act, the United States Bureau of Family Services – the agency responsible for social security programs at the time – issued a *Handbook of Public Assistance Administration*. Bureau of Family Servs., U.S. Dep't of Health, Educ., and Welfare, *Handbook of Public Assistance Administration* (1963/1964) (the "*Handbook*"). The *Handbook* was the "official medium for issuance of interpretations and instructions concerning requirements of the public assistance titles of the Social Security Act and recommendations for the administration of State public assistance programs." *Id.* at i.

The *Handbook* prohibited – as 42 C.F.R. § 431.10(e) does now – delegation by the single state agency of authority for "exercising administrative discretion in the administration or supervision of the plan" and also provided that

other state agencies performing services for the single state agency could not "substitute their judgment" for that of the single state agency. *Compare Handbook* §§ 2200(3), (5) *with* 42 C.F.R. §§ 431.10(e)(1)(i), (e)(3). The *Handbook* states that the single state agency's *purpose* was to provide a single state actor that would be accountable to the federal government for systemwide performance:

> Once the single State agency is established or designated, it is the agency of the State government that represents the State *in its dealings with the Federal agency* on all aspects of the plan and its operation. It is the agency of the State government responsible for the development and maintenance of a plan in conformity with all requirements of the Social Security Act and for the administration of the plan throughout the State. This State agency is *accountable* for the expenditure of Federal funds in accordance with the requirements of the Social Security Act, whether such funds are expended by the localities or by the State. It is *accountable* for insuring that funds will be available in all political subdivisions for assistance payments and for operation of the program on a uniform basis. The single State agency is charged with final administrative responsibility.

Handbook § 2300 (emphasis added). According to the *Handbook*, the single state agency has "continuing responsibility for the quantity, quality, utilization, and payment for services provided to recipients," but this responsibility, as expressed by the *Handbook*, clearly is imposed to promote systemwide efficiency rather than to benefit providers. *Id.* § 2310.

After the Medicaid Act was enacted in 1965, Supplement D, addressing medical assistance programs, was added to the *Handbook*. Supplement D reiterated the *Handbook*'s view that the single state agency requirement ensures systemwide performance and, in particular, ensures accountability to the federal government:

> Once the single State agency is established or designated it is the agency of the State government that represents the State in its dealings with the [federal agency in charge of Medicaid] on all aspects of the medical assistance plan and its operation. It is the agency of the State government responsible for: obtaining the statutory authority necessary to submit a plan meeting all Federal requirements; preparing the State plan and establishing policies for the operation of the program; assuring that it can carry out the plan in all political subdivisions; obtaining the State funds or the State-local funds (as the case may be); meeting all audit requirements; and being accountable to the [federal agency in charge of Medicaid] for the proper and efficient administration of the program.

Id. § D-2140 (1966).

Subsequently, the nondelegation principles set forth in the *Handbook* were codified in 42 C.F.R. § 431.10(e). Public Assistance Programs, 35 Fed. Reg. 8780 (June 5, 1970) (stating that "the proposed regulations set forth certain requirements and provisions for the public assistance programs under the Social Security Act now contained in the Handbook of Public Assistance Administration" and the "purpose is to incorporate existing requirements in the Code of Federal Regulations"). In the rulemaking that resulted in the new regulations, there is

no discussion of the purposes served by the single state agency requirement. From this silence, we can infer that 42 C.F.R. § 431.10, implementing the Medicaid Act's single state agency requirement, is premised on the same view of the single state agency requirement expressed in the *Handbook*.

In sum, we find no evidence in the text of 42 U.S.C. § 1396a(a)(5), 42 C.F.R. § 431.10(e), or in the legislative and regulatory history that Medicaid providers were the intended beneficiaries of the single state agency requirement within the meaning of *Blessing*.

B. *Significance of 42 C.F.R. § 455.23*

Our conclusion that Plaintiffs do not have a right under § 1983 to enforce the single state agency requirement does not completely resolve Defendants' appeal from the district court's summary judgments. Simonyan and Nagapetyan also urge us to affirm on the basis that DHS impermissibly withheld payments from them in violation of 42 C.F.R. § 455.23. As set forth above, 42 C.F.R. § 455.23 prohibits DHS from withholding provider payments unless DHS "recei[ves] reliable evidence" of fraud or willful misrepresentation.

The district court's conclusion that DHS withheld payments in violation of § 455.23 rested on two grounds. The district court ruled that evidence from the Controller's audit was unreliable as a matter of law because the audit resulted from an improper delegation of discretion in violation of the single state agency requirement. Our holding on the single state agency issue eliminates this ground for the district court's ruling.

We also decline Plaintiffs' invitation to affirm on a second ground. Plaintiffs contend that DHS violated § 455.23 when it failed to "receive" the evidence of fraud and independently evaluate its reliability. They argue that DHS impermissibly relied solely on the FBI's assertion in its letter that the evidence of fraud or misrepresentation was sufficient to withhold the payments.

The record reflects that DHS ultimately obtained and independently evaluated the results of the Controller's audit and other information indicating that Simonyan and Nagapetyan had billed Medi-Cal for providing more goods than they were capable of supplying. DHS concluded that the information constituted reliable evidence of fraud or willful misrepresentation. Plaintiffs do not contend that § 455.23 requires more. Because DHS ultimately complied with § 455.23, this ground for affirming the injunction is without merit.[12]

* * *

In sum, Plaintiffs cannot assert a right enforceable under § 1983. The district court erred in holding to the contrary.

IV.

Attorney's Fees

Because Plaintiffs prevailed solely due to the district court's erroneous view of the law, their attorney's fee awards must be reversed. *See Lovell v. Poway Unified Sch.*

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[12] Because of the resolution of this issue, we do not reach the question of whether 42 C.F.R. § 455.23 creates a private right of action that a provider may enforce under § 1983.

Dist., 90 F.3d 367, 373-74 (9th Cir. 1996) ("[b]ecause we have reversed the judgment . . . on the merits, [plaintiff] can no longer be considered a prevailing party"); *see also Ward v. County of San Diego*, 791 F.2d 1329, 1334 (9th Cir. 1986) ("[a]n erroneously granted injunction cannot be the basis for an award of attorney fees as the prevailing party").

V.

Conclusion

We conclude that the district court erred in holding that Plaintiffs can maintain an action under § 1983 to enforce compliance with the single state agency requirement. Accordingly, we reverse the district court's judgments in favor of Plaintiffs Simonyan and Nagapetyan in case no. 00-55377 and Plaintiff Clinical Care in case no. 00-55963, and remand case no. 00-55377 for the district court to enter judgment for Defendants. In *Clinical Care*, although it appears that the district court resolved all of Clinical Care's claims, we cannot be certain. Therefore, we remand case no. 00-55963 to the district court to resolve any remaining claims. Because San Lazaro's claims are moot, we dismiss the appeal in case no. 00-55065. We also reverse the district court's attorney's fee awards in favor of all Plaintiffs. Finally, in *San Lazaro* (case no. 00-55610), the Controller sought attorney's fees following the district court's order vacating the summary judgment. We note that the district court denied the Controller's motion for summary judgment and, having granted San Lazaro's request for attorney's fees, summarily denied the Controller's motion for attorney's fees. We remand case no. 00-55610 to the district court to consider the Controller's request for attorney's fees in light of our ruling.

DISMISSED IN PART, REVERSED IN PART, and REMANDED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 00-55065
CT/AG#: CV-98-06216-RJK

SAN LAZARO ASSOCIATION, INC., d/b/a Biomedical Laboratory

Plaintiff-Appellee

v.

KATHLEEN CONNELL, Controller of the State of California

Defendant-Appellant

NO. 00-55610
CT/AG#: CV-98-06216-RJK

SAN LAZARO ASSOCIATION, INC., dba Biomedical Laboratory

Plaintiff-Appellee

v.

KATHLEEN CONNELL, Controller of the State of California

Defendant-Appellant

NO. 00-55377
CT/AG#: CV-99-02420-RJK

OGANES NAGAPETYAN; KHACHIK SIMONYAN

Plaintiffs-Appellees

v.

KATHLEEN CONNELL, Controller of the State of California; JOSEPH MUNSO, Chief

Deputy Director of the California Dept of Health Services

Defendants-Appellants

NO. 00-55963
CT/AG#: CV-98-08425-RJK

CLINICAL CARE LABORATORY, INC.

Plaintiff-Appellee

v.

KATHLEEN CONNELL, Controller of the State of California; S. KIMBERLY BELSHE, Director of the Department of Health Services

Defendants-Appellants

APPEAL FROM the United States District Court for the Central District of California, Los Angeles.

THIS CAUSE came on to be heard on the Transcript of the Record from the United States District Court for the Central District of California, Los Angeles and was duly submitted.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court, that the judgment of the said District Court in this cause be, and hereby is DISMISSED in part, REVERSED in part, and REMANDED.

Filed and entered January 24, 2002

Amended April 17, 2002

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

KHACHIK SIMONYAN and OGANES NAGAPETYAN,
Plaintiffs,

v.

KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA and JOSEPH MUNSO, CHIEF DEPUTY DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES
Defendants.

CASE NO. 99-2420 RJK

MEMORANDUM OF DECISION AND ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

(Filed Jan. 20, 2000)

Pursuant to Rule 56 of the Federal Rules of Civil Procedure, Plaintiffs Khachick Simonyan ("Simonyan"), sole proprietor of Eagle Medical Supply ("Eagle Medical") and Oganes Nagapetyan ("Nagapetyan"), sole shareholder of Nairi Pharmacy, Inc. ("Nairi Pharmacy"), filed a Motion for Summary Judgment. Defendants Kathleen Connell, Controller of the State of California ("Controller"), and Joseph Munso, Chief Deputy Director of the California Department of Health Services ("DHS"), filed a countermotion for summary judgment. This Court took both motions under submission, and has considered the moving and responding papers. For the reasons set forth below, the Court GRANTS Plaintiffs Simonyan and Nagapetyan's Motion for Summary Judgment and DENIES Defendants Connell and Munso's Motion for Summary Judgment.

I. Statement of Facts

The following facts are uncontroverted:

On March 9, 1999, Plaintiffs Simonyan and Nagapetyan filed a Complaint for Injunctive and Declaratory Relief and Damages Under the Civil Rights Act, 42 U.S.C. § 1983 et seq. ("Complaint"), against Kathleen Connell, the Controller of the State of California, and Joseph Munso, the Chief Deputy Director of the California Department of Health Services.

Both Plaintiffs are providers of medical supplies and equipment under California's Medi-Cal program. During 1998, the Controller audited Medi-Cal claims and payments of various providers of medical equipment and supplies, including Eagle Medical and Nairi Pharmacy.

A. The Interagency Agreement Between the Controller and the State Department of Health Services

DHS has contracted with a private company, Electronic Data Services ("EDS"), to act as the Medi-Cal fiscal intermediary for purposes of processing claims submitted by Medi-Cal service providers. DHS's contract with EDS is specifically permitted under the governing federal Medicaid regulations and state law and is part of the state Medicaid plan. *See* 42 C.F.R. § 434.10 (1999); *see also* Cal. Welf. & Inst. Code § 14104.3 (West 1991 & Supp.2000).

EDS reviews each Medi-Cal claim submitted by a provider and determines the amount of Medi-Cal payment owing for services furnished to Medi-Cal patients by applying Medi-Cal regulations. EDS then advises the Controller of the sum owing to the Medi-Cal services

provider. The Controller is required to promptly issue a warrant (i.e., a check) to the Medi-Cal services provider for that sum.

In July 1997, DHS and the Controller entered into an "Interagency Agreement," which purported to allow the Controller to perform certain Medi-Cal audit functions. The audits were performed to identify and recover Medi-Cal overpayments to providers. The Interagency Agreement stated that "DHS will review all reports of overpayments identified by [the Controller] for policy and procedural implications." Interagency Agreement at 2 (July 1, 1997).

B. The Amended Interagency Agreement Between the Controller and the Department of Health Services

Effective July 1, 1998, DHS and the Controller amended the original Interagency Agreement ("Amended Interagency Agreement"). The Amended Interagency Agreement purportedly corrects the deficiencies found by this Court, in this and other related cases, and by the California Court of Appeal in *Doctor's Med. Lab., Inc. v. Connell*, 69 Cal.App. 4th 891 (1999). In particular, the Amended Interagency Agreement states that "DHS will exercise its authority as the Medicaid single state agency." Amended Interagency Agreement at 3-4 (July 1, 1998).

C. Eagle Medical Supply

On May 21, 1998, the Controller released her audit findings for Eagle Medical, relative to billings for products from January 1, 1997 through November 30, 1997. According to the Controller, Eagle Medical's records did not

adequately support the amounts paid to Eagle Medical by the Medi-Cal program during the period under review. On the same date that the Controller wrote to Eagle Medical about her audit findings, she also urged DHS to take immediate administrative action against Eagle Medical.

On June 17, 1998, Eagle Medical requested an administrative hearing before DHS to challenge the audit findings of the Controller. DHS scheduled an administrative hearing on Eagle Medical's challenge to the Controller's audit findings. The hearing was scheduled to commence on May 18, 1999. However, on February 4, 1999, the Controller requested a continuance of the Medi-Cal administrative hearings on the grounds that the Controller did not want to interfere with the Federal Bureau of Investigation's ("FBI") ongoing criminal investigation of Eagle Medical.

On February 16, 1999, DHS informed Eagle Medical that "based upon reliable information received" from the FBI, DHS had concluded that Eagle Medical had "allegedly engaged in wilful misrepresentation or fraud in regard to the Medi-Cal program." Controller's Letter to Eagle Medical at 2 (February 16, 1999). DHS therefore determined that all current Medi-Cal payments made to Eagle Medical would be withheld and suspended until Medi-Cal or prosecuting authorities determined there was insufficient evidence of fraud or misrepresentation or after legal proceedings relating to the alleged fraud or misrepresentation were completed.

D. Nairi Pharmacy

On July 31, 1998, the Controller informed Nairi Pharmacy that based upon its audit of Nairi Pharmacy's

billings to the Medi-Cal program for prescription products from July 1, 1997 through January 23, 1998, Nairi Pharmacy had been overpaid the sum of $113,861. Unlike Eagle Medical, Nairi Pharmacy did not request an administrative hearing to challenge the Controller's audit findings.

On February, 16, 1999, DHS issued an almost identical letter to Nairi Pharmacy indicating that it was temporarily withholding 100% of the Medi-Cal payments to Nairi Pharmacy under 42 C.F.R. § 455.23. Like the letter to Eagle Medical, the letter to Nairi Pharmacy was also "based upon reliable information received" from the FBI, which caused DHS to conclude that Eagle Medical had "allegedly engaged in wilful misrepresentation or fraud in regard to the Medi-Cal program." Controller's Letter to Nairi Pharmacy at 2 (February 16, 1999). Nairi Pharmacy objected to State DHS's February 16, 1999 determination to withhold all Medi-Cal payments.

E. The Letter From the Federal Bureau of Investigation

The letters sent out to both Eagle Medical and Nairi Pharmacy on February 16, 1999 were prompted by a letter that Al Schaden, Chief of the Case Development Section in the Medical Review Branch of the Audits and Investigation Division of the Department of Health Services, received from the Supervisory Special Agent of the FBI, James J. Wedick Jr. on February 4, 1999. Within this letter, Mr. Wedick requested that DHS withhold payments made to ninety-one (91) medical providers that were identified in a document attached to the letter. He stated

that all providers were presently subjects of "pending criminal cases and/or inquiries." He explained that the

> inquiries and/or cases [had] been initiated based on reliable and credible evidence, received either in whole or in part, from (1) the [California State Controller's Office] indicating "fraud", (2) made pending due to statements taken from Cooperating Witnesses (CWs) claiming "fraud", and/or (3) were opened and/or are being opened based on results of a preliminary examination by agents suggesting "fraud."

Wedick's Letter to Schaden (February 4, 1999). This letter does not identify which source of evidence corresponded to which healthcare provider. It does not expand on how the Controller's office determined that there was fraud. It does not explain what a preliminary examination by an FBI agent would entail. It simply states that every provider listed had evidence of fraud against it based upon at least one of the three sources identified above.

A few weeks later, Mr. Schaden determined that withholds should be placed on all 91 healthcare providers referenced in the letter. He based his decision on a review of the letter and the fact that he knew that a case agent would not be assigned to a medical provider, as had happened in all 91 cases, unless the FBI had reliable evidence of fraud.

F. The Parties' Positions

Plaintiffs allege that the Controller and DHS are withholding the Medi-Cal payments in violation of federal law, *Doctor's Medical Laboratory v. Connell*, 69 Cal.App.

4th 891 (1999), and this Court's April 9, 1998 Memorandum of Decision and Order in the related case of *Health Line Clinical Laboratory, et al. v. Kathleen Connell, et al.*, CV 98-1620 RJK (*"Health Line"*).[1] In particular, Plaintiffs allege that DHS has unlawfully delegated Medi-Cal audit authority to the Controller and that the Controller, in turn, has unlawfully assumed and exercised that responsibility to the substantial detriment of the Plaintiffs.

Pursuant to Fed.R.Civ.P. 56, Plaintiffs move this Court for summary judgment on the ground that there is no genuine issue as to any material fact. Plaintiffs contend that they are entitled to judgment as a matter of law as the Controller continues to perform audits of Medi-Cal service providers in direct violation of federal Medicaid laws.

As with the other related cases, Defendants vigorously oppose Plaintiffs' motion. Further, Defendants also move for summary judgment on the ground that the withhold placed on both Plaintiffs' Medi-Cal payments was proper and in full compliance with federal Medicaid law. They contend that because the actions were lawful, no injunction would be appropriate, and that they should prevail on their summary judgment motion.

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[1] *See* April 9, 1998, MD & O at 16: "The Controller, in all future actions with respect to Medi-Cal audits performed, shall comply fully with all federal Medicaid laws and regulations, as well as with all applicable Welfare and Institutions Code and California Code of Regulations sections, as it agreed to do in the Interagency Agreement with [the State Department of Health Services ("state DHS")], and as required under federal law."

II. Summary Judgment Standard

The standard set for summary judgment is clear. The Federal Rules of Civil Procedure provide for summary adjudication when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(e). Material facts which would preclude entry of summary judgment are those which, under applicable substantive law, may affect the outcome of the case. The substantive law will identify which facts are material. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The court must view the facts and draw inferences in the manner most favorable to the non-moving party. *See Chaffin v. United States*, 176 F.3d 1208, 1213 (9th Cir.1999).

In a motion for summary judgment, "[i]f the party moving for summary judgment meets its initial burden of identifying for the court those portions of the materials on file that it believes demonstrate the absence of any genuine issues of material fact," the burden of production then shifts so that "the nonmoving party must set forth, by affidavit or as otherwise provided in Rule 56, 'specific facts showing that there is a genuine issue for trial.'" *T.W. Elec. Service, Inc. v. Pacific Elec. Contractors Ass'n*, 809 F.2d 626, 630 (9th Cir.1987) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986)); *Kaiser Cement Corp. v. Fischbach & Moore, Inc.*, 793 F.2d 1100, 1103-04 (9th Cir.1986). "[A] mere 'scintilla' of evidence will be insufficient to defeat a properly supported motion for summary judgment; instead the nonmoving party must introduce some 'significant probative evidence tending to support the complaint.'"

Fazio v. City of San Francisco, 125 F.3d 1328, 1331 (9th Cir.1997) (quoting *Anderson*, 477 U.S. at 249, 252).

In judging evidence at the summary judgment stage, the court does not make credibility determinations or weigh conflicting evidence. Rather, the court must draw all reasonable inferences in favor of the party against whom summary judgment is sought. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Intel Corp. v. Hartford Accident and Indem. Co.*, 952 F.2d 1551, 1558 (9th Cir.1991). However, if no factual showing is made in opposition to a motion for summary judgment, the district court is not required to search the record sua sponte for some genuine issue of material fact. It may rely entirely on the evidence designated by the moving party showing no such triable issue. *See Guarino v. Brookfield Township Trustees*, 980 F.2d 399, 403 (6th Cir.1992).

III. Analysis

Some of the following analysis duplicates that given in *San Lazaro Association, Inc. v. Connell*, CV 98-6216 RJK, as many of the underlying issues, facts and circumstances surrounding the present case existed within the San Lazaro action.

A. Federal Medicaid Law Prohibits the Controller from Exercising Administrative Discretion in Connection with the Administration of the Medi-Cal Program

1. Federal Single State Agency Medicaid Requirements

Medi-Cal payments to patients are funded with federal moneys provided under the Medicaid legislation.

To obtain federal moneys, the states must comply with the federal statutory and regulatory requirements of Medicaid. See 42 U.S.C. § 1396(a) (1999); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Doctor's Med. Lab., Inc. v. Connell*, 69 Cal.App. 4th 891, 894 (1998).

Federal law specifies that a state must designate a single agency to administer its Medicaid plan. *See* 42 U.S.C. § 1396(a)(5) (1999). Further, that single state agency is forbidden under federal law from delegating, except to its own officials, authority to exercise discretion in administering the plan. *See* 42 C.F.R. §§ 431.10(e)(1)-(3) (1999). Federal regulations permit the designated agency to use services of other state agencies, but not to delegate administrative discretion to such agencies:

> If other State . . . agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

42 C.F.R. § 431.10(e)(3) (1999).

2. The Controller Violates Federal Medicaid Laws by Exercising Discretion During Audits, Reviews and Investigations of Medi-Cal Service Providers

Plaintiffs Simonyan and Nagapetyan contend that, like in *San Lazaro* and other cases before this Court, the Defendants are violating Medicaid's "single state agency" requirement, and that summary judgment in Plaintiffs'

favor is proper. In particular, Plaintiffs contend that the Controller's audits of Medi-Cal payments and claims are in direct violation of the single state agency requirement that no other agency may exercise administrative discretion in connection with the administration of the Medi-Cal program. In contrast, Defendants contend that the withhold placed on both parties was based on an FBI recommendation, not any audit by the Controller. Consequently, Defendants urge that any argument regarding the Controller's audit is irrelevant. They further argue that any audits conducted by the Controller are proper under federal Medicaid law because federal Medicaid law does not prohibit the Controller from auditing, reviewing or investigating Medi-Cal payments and claims. For these reasons, Defendants contend that summary judgment in their favor is proper.

a. Federal Single State Agency Medicaid Requirements Prohibit the Controller from Exercising Any Discretionary Authority with Respect to a Medi-Cal Plan

Federal Medicaid requirements allow DHS to obtain services from other state and local agencies in the administration of the Medi-Cal plan. *See* 42 C.F.R. §§ 431.10(e)(1)-(3) (1999). However, DHS is limited in that it may not delegate administrative discretion to any of those state or local agencies. *See id.* Thus, any state or local agency, other than DHS, that attempts to exercise discretionary authority in the administration of the Medi-Cal plan is in direct violation of the federal single state agency requirements. As this Court noted in *Health Line*, any agency violating federal Medicaid requirements may be enjoined from so doing. *See* April 9, 1998, MD & O at 8.

In *Health Line*, this Court had the opportunity to review the original Interagency Agreement in connection with a Medi-Cal service provider's Complaint for Declaratory and Injunctive Relief. This Court found that "[b]ecause of the supremacy of federal law in th[e] area [of Medicaid], no interagency agreement could give the Controller more power than the State DHS ha[d] the authority to delegate." *Health Line*, April 9, 1998, MD & O at 6. This Court held that the "Controller, or any other state agent, may be enjoined in federal court from acting inconsistently with the policies and procedures of State DHS with respect to the Medi-Cal program, as required under 42 C.F.R. § 431.10(e), and must comply with 42 C.F.R. §§ 455.13 & 455.23 if Medi-Cal funds are to be withheld from Plaintiffs." *Id.* at 8.

Little has been presented to the Court regarding the specifics of the audit. It is not clear how the audit was initiated, under whose authority it began or for what purpose. Further, little mention is made as to what exactly occurred during the audit. What is known is that the notice of an audit was sent to Eagle Medical on May 21, 1998 and to Nairi Pharmacy on July 31, 1998. In both notices the Controller stated that it had "reviewed" each company's business records relative to its billings to the Medi-Cal program for a specified duration. The letters also state that the records do not "adequately support the amounts paid" to either of the companies. It also mentions that "other products with dates of service within the review period that have not yet been analyzed, as well as other products with dates of services in different periods, are still subject to review." Notwithstanding the paucity of evidence submitted, the letters sent to the Plaintiffs make clear that the Controller's office is exercising discretion.

The Controller's office determined the specific products and time period of the audit, and employees conducted analyses and reviews while performing the audit. All of these actions constitute improper acts of discretion.

The discretionary functions that the Controller has exercised above were clearly based upon the authority given to her office under the Amended Interagency Agreement. A review of the Amended Interagency Agreement reveals that the Controller retains a significant amount of discretion in the administration of the Medi-Cal plan under the Agreement. For example, the Amended Interagency Agreement states that:

> [The Controller] will be responsible for the tracking and resolution, including legal representation if needed, of the findings identified in [her] reviews, audits, or investigations. Such responsibility will extend through and include the administrative appeal process before the DHS Office of Administrative Hearings and Appeals (OAHA) under Welfare and Institutions Code section 14171.

Amended Interagency Agreement at 3. Thus, the Controller is allowed absolute discretion to audit, investigate, and even possibly litigate, potentially invalid Medi-Cal claims made by Medi-Cal service providers. As has been said before, such sweeping powers very nearly define the complete exercise of discretionary authority.

b. DHS Must *Receive* Reliable Evidence from a *Permissible* Source Before It Initiates a Withhold of Payments

Defendants argue at length that DHS, not the Controller, withheld the Medi-Cal payments to the Plaintiffs and, in so doing, DHS exercised its own discretion as the single state agency administering Medi-Cal. Further, it argues that DHS made the withhold at the express recommendation of the FBI, not the Controller, so that anything that the Controller's office did in auditing was irrelevant to the decision to withhold the payments.

It is undisputed that DHS exercised its own discretion when it authorized the withhold of Medi-Cal payments to Eagle Medical and Nairi Pharmacy, and it is also undisputed that DHS did so at the express request of the FBI. However, DHS did not use its own discretion in determining whether the evidence supporting the withhold was *reliable* as is necessary under 42 C.F.R. § 455.23. The regulations specifically provide that the "State Medicaid agency may withhold Medicaid payments, in whole or in part, to a provider upon *receipt of reliable evidence* that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program." 42 C.F.R. § 455.23 (1999) (emphasis added). No such reliable evidence was provided to DHS in this instance.

Al Schaden himself, the DHS employee responsible for the decision to withhold the payments, states in his declaration that he based his decision to withhold the funds on Special Agent James Wedick's letter and the fact that he knew that the FBI would not assign an agent unless they had reliable evidence. As was described earlier in this Order, the letter did not tell Schaden any of the

evidence the FBI possessed. Rather, Schaden simply took at face value the FBI agent's word that reliable evidence existed. Although this may have been true, the State Medicaid agency, DHS, must *receive* this evidence and determine *for itself* if such evidence is reliable. Because DHS based its decision to withhold the payments upon the FBI's promise of reliable evidence rather than the actual receipt of reliable evidence of fraud, the withhold was improper and must be lifted.

The impropriety of DHS's decision is further highlighted by the fact that it is likely that the "reliable evidence" referred to in Wedick's letter was in fact the improper audit conducted by the Controller's office. Within the overwhelmingly and unnecessarily voluminous number of papers submitted to this Court for these motions, the Court found no mention of an investigation being conducted by the FBI or DHS, nor cooperating witnesses being located prior to the February 16, 1999 decision to withhold the payments. The first mention of any investigation or cooperating witnesses occurred in the March 24, 1999 affidavit submitted by Special Agent Wedick. The affidavit does not mention when the witnesses were located nor when the investigation was initiated (beyond the assignment of the agent to the provider). It is likely that the only "reliable evidence" that the FBI had in its possession when it recommended the withhold was the 1998 audits conducted by the Controller's office. Again it must be stressed that evidence that has been compiled by the Controller's office through an audit which allows for any amount of discretion (e.g. defining parameters of the audit and analyzing submissions) is improper and cannot be considered reliable. And in any event, *no* evidence,

reliable or otherwise, was presented to DHS before it made its decision to withhold.

c. A Review of the Controller's Audit by DHS or the FBI or Any Other Agency Will Not Transform the Audit Into Reliable Evidence

Although it has been said before in both *San Lazaro* as well as *Doctor's Medical Laboratory Inc. v. Connell*, it bears repeating: even assuming that DHS performed a discretionary review of the evidence given by the FBI, if it was work performed by the Controller, DHS's discretionary review would not undo DHS's delegation of discretionary power to the Controller under the Amended Interagency Agreement. In *Doctor's*, 69 Cal.App. 4th 891 (1999), the California Court of Appeal reviewed federal Medicaid statutes and regulations in conjunction with a review of the original Interagency Agreement between DHS and the Controller. In response to a contention by the Controller that DHS reviewed the Controller's reports and recommendations, the court noted that a DHS review of the reports of overpayments identified by the Controller for policy and procedural implications would not save the delegation of authority from violating federal law. *Id.* at 897. The court held that "[t]he express ban on delegating discretionary power contain[ed] no exception permitting delegation so long as decisions [we]re later 'reviewed' (in some unspecified manner) by the designated 'single agency.' The bar to delegation of discretionary power would be easily circumvented if such a provision in an interagency agreement were given effect." *Id.* Obviously, if a review by the single state agency, DHS, is not sufficient, a

review by the FBI or a review by DHS of the FBI's review, would not be sufficient either.

Any form of review or analysis by the Controller is discretionary and cannot be the basis for the withhold. Whether directly, through audits and recommendations submitted immediately to DHS itself, or indirectly, through findings submitted to the FBI who then makes recommendations based upon the Controller's findings to DHS, the Controller's audit may not be used as reliable evidence for determining a proper withhold. Because any review and analysis by the Controller involves some measure of discretion, it is in direct violation of the Medicaid regulation forbidding delegation of discretionary authority outside of the single state agency. *See* 42 C.F.R. § 431.10(e)(3) (1999).

Pursuant to federal Medicaid requirements, specifically 42 C.F.R. § 431.10(e) (1999), the Controller is prohibited from exercising any discretionary authority in the administration of California's Medi-Cal plan. This prohibition includes performing audits, reviews, or investigations where the Controller exercises *any discretionary authority*. Actions such as determining the parameters of an audit, appraising whether the submissions were "reasonable" and performing any form of analysis all are examples of actions that involve some level of discretion which cannot be allowed.

3. The Controller is Prohibited From Conducting Audits of Medi-Cal Service Providers by the California Court of Appeal's Decision in Doctor's

Plaintiffs Simonyan and Nagapetyan contend, as did the Plaintiff in *San Lazaro*, that the California Court of Appeal's decision in *Doctor's* explicitly prohibits the Defendant Controller from conducting audits of Medi-Cal service providers. The Defendants counter that the Court of Appeal's decision in Doctor's only "focused on the [Interagency Agreement]'s delegation to the Controller of the authority to take 'corrective action.'" The Defendants contend that *Doctor's* does not prohibit the Controller's office from conducting audits of Medi-Cal service providers.

As discussed above and in *San Lazaro*, the California Court of Appeal in *Doctor's* reviewed federal Medicaid statutes and regulations in conjunction with a review of the original Interagency Agreement between DHS and the Controller. The court found that the original Interagency Agreement "authorized the *Controller* to audit provider claims and 'take corrective action.'" *Doctor's*, 69 Cal.App. 4th at 896 (emphasis in original). The court found that the "delegation of these powers to the Controller was contrary to DHS's representation to the federal government (in DHS's Medicaid plan) that *audits and corrective action would be DHS's province.*" *Id.* at 896-97 (emphasis in original). Finally, the court held that "[t]he Controller could not lawfully exercise power to audit provider payments and withhold alleged excesses." *Id.* at 897.

Subsequent to the California Court of Appeal's decision in *Doctor's*, the Controller filed a Petition for Rehearing or in the alternative, Request for Depublication,. In

the Petition, the Controller argued that the *Doctor's* opinion "implie[d] that all delegations of auditing services by the single state agency designated to administer California's Medicaid plan, the Department of Health Services, [we]re prohibited by federal law." Appellant's Pet. for Reh'g at 1. The Controller's Petition was rejected by the Court of Appeal.

On March 15, 1999, the Controller filed a Petition for Review, or, in the Alternative, Request for Depublication with the California Supreme Court. In the Petition, the Controller again argued that the Court of Appeal's decision in *Doctor's* "at least implie[d] that the Controller c[ould] not exercise *any* audit function, even under the direction of the DHS." Appellant's Pet. for Review at 4. On May 26, 1999, the Supreme Court denied both the Controller's Petition for Review as well as the Request for Depublication.

The language used in Doctor's is clear: DHS may not delegate the authority to take corrective action *or conduct an audit*. The argument that since the Doctor's Court focused on the portion allowing corrective action, it would have allowed the Controller to audit is not supported within the text of the opinion itself or even the Controller's own subsequent arguments. The Controller's arguments to both the California Court of Appeal and the California Supreme Court reveal that the Controller fully appreciates the true meaning and importance of the Doctor's decision. Nevertheless, the Defendants still cling to the position that the Controller may conduct an audit. This Court does not know how to state it more clearly: *the Controller may not perform any discretionary activity within an audit of health care providers under DHS's Medicaid plan and federal Medicaid law.* Therefore, the Court again rejects

the Controller's current interpretation of the *Doctor's* opinion.

It is undisputed that the Controller continues to perform audits of Medi-Cal service providers. It is also undisputed that the Controller is performing these audits pursuant to the Amended Interagency Agreement between the Controller and DHS. Finally, it is beyond dispute that the Controller's audits of Medi-Cal service providers are in direct violation of the Court of Appeal's holding in *Doctor's*, that "[t]he Controller could not lawfully exercise power to audit provider payments. . . . " *Doctor's*, 69 Cal.App. 4th at 897. To say that the Controller may not conduct audits but then allow these audits to be considered "reliable evidence" supporting a withhold of payments would permit Defendants to circumvent the prohibition and accomplish indirectly what they cannot accomplish directly.

As there exists no genuine issues of material fact regarding the actions taken by Defendant Controller with respect to the audits of Eagle Medical and Nairi Pharmacy and the course of events leading up to the withholding of payments by DHS, this motion presents purely a question of law. Since the Controller is barred from performing audits that entail administrative discretion, Plaintiffs Simonyan and Nagapetyan are entitled to summary judgment on their claim that the Controller violated Medicaid's single state agency requirement.

B. Plaintiffs Simonyan and Nagapatyen Have A Private Right of Action to Enforce Provisions of the Medicaid Act Which Prohibit the Delegation of Authority Outside of the Single State Agency

Defendants Controller and DHS contend that Plaintiffs Simonyan and Nagapetyan do not have a private right of action to enforce the provisions of the Medicaid Act which prohibit the delegation of authority outside of the single state agency. In particular, the Defendants contend that the enforcement of provisions relating to the prevention of fraud are to be enforced by the Secretary of Health and Human Services. Plaintiffs counter that the federal Medicaid regulations, as well as this Court's previous orders in several related cases, provide for a private right of action to enforce provisions of the Medicaid Act which prohibit the delegation of authority outside of the single state agency. As this issue has been thoroughly addressed in several orders by this Court involving at least one of the same defendants and the exact same defense counsel, this Court need only cursorily explain again why Defendants' position fails.

A plaintiff can allege a cause of action under 42 U.S.C. § 1983 against any person, who, under color of state law, deprives another of "any rights, privileges or immunities secured by the Constitution and laws [of the United States]." As this Court noted in *Health Line*, "[r]elief under 42 U.S.C. § 1983 is not limited to federal constitutional violations but also may be based on violations of a federal statute." April 9, 1998, MD & O at 3; *see also Maine v. Thiboutot*, 448 U.S. 1, 6-8 (1980). However, as § 1983 is addressed to the deprivation of "rights, privileges or immunities" and not merely violations of federal law, the

plaintiff must show that the federal law violated creates enforceable rights within the meaning of § 1983. *See Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 106 (1989).

After a thorough analysis of all the *Health Line* defendant's arguments, this Court agreed with the plaintiffs who had argued that 42 C.F.R. § 431.10(e) was "intended to protect Medi-Cal providers, such as themselves, from falling victim to unauthorized state action, such as that alleged against the Controller." April 9, 1998, MD & O at 5-6. This Court found that the "Interagency Agreement itself require[d] the Controller to abide by various Welfare and Institutions Code sections, as well as procedural regulations of State DHS, which were clearly intended for the benefit of providers." *Id.* at 6.

This Court also noted in *Health Line* that the single state agency requirements "were undoubtedly intended to benefit [Medi-Cal service providers], and not merely to promote the efficient administration of the state plan. . . . " *Id.* at 8. Further, this Court held that the single state agency requirements were "mandatory, not at all vague, and specific and detailed enough so that the court [could] 'examine exactly what is required of the States.'" *Id.* at 8 (citations omitted).

The California Court of Appeal's decision in *Doctor's Medical Laboratory Inc. v. Connell* also supports this Court's determination that private plaintiffs have a right to enforce specific provisions of the federal Medicaid Act. In finding that Medi-Cal service providers had a private right to enforce the single state agency requirements, the California Court of Appeal noted that:

> "[P]rompt, knowledgeable, fair review and payment of provider claims are essential to the basic statutory purpose to provide medical care to the indigent and elderly. Private providers will soon be discouraged from offering Medicaid services if they are not paid promptly and fairly for their services. Indeed, providers will not be *able* to provide such services if they go out of business because the state improperly withholds payments. . . .

69 Cal. App. 4th at 898 (emphasis in original).

Given this Court's previous rulings in *Health Line, San Lazaro*, and others, the Defendants' contention that Plaintiffs do not have a private right of action to enforce the Medicaid Act is once again rejected. Therefore, this Court finds that Plaintiffs Simonyan and Nagapetyan have a private right of action to enforce the provisions of the Medicaid Act, specifically those prohibiting the violation of the single state agency requirements.

IV. Disposition

For all of the reasons set forth above, and pursuant to Rule 56 of the Federal Rules of Civil Procedure, the Motion for Summary Judgment by Plaintiffs Simonyan and Nagapetyan is GRANTED, while the Motion for Summary Judgment by Defendants Connell and Munso is DENIED.

The Defendant Controller of the State of California, her employees, agents, and others acting in concert with her are enjoined from auditing, reviewing, or investigating Medi-Cal payments and claims of these Plaintiffs. The Chief Deputy Director of the California Department of

Health Services, his employees, agents, and others acting in concert with him are enjoined from basing a Medi-Cal withhold, either directly or indirectly, upon audits of Plaintiffs performed by the Controller. DHS is also enjoined from withholding payments to Plaintiffs based upon evidence that has not been both received and analyzed by DHS itself to determine its reliability.

IT IS SO ORDERED.

DATE: Jan. 20, 2000

/s/ Robert J. Kelleher
ROBERT J. KELLEHER
United States District
Judge

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

CLINICAL CARE LABORATORY, INC., Plaintiffs, v. KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA and S. KIMBERLY BELSHE, DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES, STATE OF CALIFORNIA, Defendants,	Case No.: 98-8425 RJK (BQRx) [~~PROPOSED~~] JUDGMENT (Filed April 25, 2000)

Defendants having moved to dismiss for lack of subject matter jurisdiction pursuant to Rule 12(h)(3) of the Federal Rules of Civil Procedure and for mootness, and Plaintiff and Defendants having each moved separately for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure, and the Court having granted Plaintiff's Motion for Summary Judgment and denied Defendants' Motion to Dismiss the Complaint for Lack of Subject Matter Jurisdiction and for Mootness and Defendants' Motion for Summary Judgment on April 3, 2000,

IT IS HEREBY ORDERED, ADJUDGED, AND DECREED that:

1. Defendants' Motion to Dismiss for Lack of Subject Matter Jurisdiction and for Mootness is denied;

2. Defendants' Motion for Summary Judgment is denied;

3. Plaintiff's Motion for Summary Judgment is granted;

4. Defendant State Controller, her employees, her agents, and others acting in concert with her, are enjoined from future auditing, reviewing or investigating of Medi-Cal claims of this Plaintiff; and

5. Defendant State Controller is enjoined from representing the California Department of Health Services ("DHS") as its legal representative in the pending administrative appeal of this Plaintiff before the DHS' Office of Administrative Hearings and Appeals.

DATED: 4-21-00

/s/ Robert J. Kelleher
ROBERT J. KELLEHER
Senior United States
District Judge

Submitted by:

BILL LOCKYER, Attorney General of the State of California
JOHN H. SANDERS, Supervising Deputy Attorney General
SANDRA L. GOLDSMITH, Deputy Attorney General

By: /s/ Sandra L. Goldsmith
SANDRA L. GOLDSMITH
Deputy Attorney General
Attorneys for Defendants

DATED: April 7, 2000

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

CLINICAL CARE LABORATORY, INC.,

Plaintiff,

v.

KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA and S. KIMBERLY BELSHE, DIRECTOR OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES,

Defendants.

CASE NO. CV 98-8425 RJK

MEMORANDUM OF DECISION AND ORDER GRANTING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANTS' 1) MOTION FOR SUMMARY JUDGMENT AND 2) MOTION TO DISMISS FOR LACK OF SUBJECT MATTER JURISDICTION

(Filed Apr. 24, 2000)

I. Introduction and Procedural Background

On October 15, 1998, Plaintiff Clinical Care Laboratory, Inc. ("Clinical Care") filed a Complaint for Injunctive and Declaratory Relief and Damages Under the Civil Rights Act, 42 U.S.C. § 1983 et seq ("Complaint"), against Kathleen Connell, the Controller of the State of California ("Controller"), and S. Kimberly Belshe, Director of the Department of Health Services of the State of California ("DHS"). The Complaint sought to enjoin both the Controller and DHS from withholding Plaintiff's Medi-Cal payments and enjoin the Controller only from reviewing Plaintiff's Medi-Cal claims and payments.

On October 27, 1998, the Court issued an OSC Regarding Preliminary Injunction and Temporary Restraining Order. The temporary restraining order enjoined Defendants "from withholding any Medi-Cal moneys from plaintiff for clinical laboratory services furnished on behalf of Medi-Cal patients." The temporary restraining order did not mention whether the Controller could audit or review Plaintiff's Medi-Cal claims and payments.

On November 9, 1998, Defendants filed a motion to dismiss the complaint pursuant to Fed. R. Civ. P. 12(b)(1) and 12(b)(6). On December 2, 1998, the Court granted Plaintiff's request for a preliminary injunction. The Order Granting Preliminary Injunction again enjoined Defendants from Continuing to withhold all Medi-Cal payments from Plaintiff but did allow them to withhold fifty percent of the sums for future billings until the amount owing Plaintiff was finally decided. On December 7, 1998, Defendants' motion to dismiss was denied.

On February 9, 1999, the Court issued an OSC Re: Dismissal for Lack of Prosecution. Plaintiff filed a timely response thereto. In the early spring, a few discovery disputes arose, but no substantive motions were filed. No action was taken by either party to this lawsuit from May 20, 1999 until this Court issued a OSC Re: Dismissal for Noncompliance with Local Rule 6.5. Plaintiff responded by filing Plaintiff's Motion for Summary Judgment on February 15, 2000. Defendants then filed their own motion for summary judgment, and later a renewed motion to dismiss under Fed. R. Civ. P. 12(h)(3). The usual flurry of filings have occurred between the parties.

II. Statement of Facts

The following facts are uncontroverted unless specifically indentified otherwise:

A. The Interagency Agreement Between the Controller and the State Department of Health Services

DHS has contracted with a private company, Electronic Data Services ("EDS"), to act as the Medi-Cal fiscal intermediary for purposes of processing claims submitted by Medi-Cal service providers. DHS's contract with EDS is specifically permitted under the governing federal Medicaid regulations and state law and is part of the state Medicaid plan. *See* 42 C.F.R. § 434.10 (1999); *see also* Cal. Welf. & Inst. Code § 14104.3 (West 1991 & Supp. 2000).

EDS reviews each Medi-Cal claim submitted by a provider and determines the amount of Medi-Cal payment owing for services furnished to Medi-Cal patients by applying Medi-Cal regulations. EDS then forwards the claims that it identifies as eligible for payment to the Controller. The Controller is required to promptly issue a warrant (i.e., a check) to the Medi-Cal services provider for that sum.

In July 1997, DHS and the Controller entered into an "Interagency Agreement," which purported to allow the Controller to perform certain Medi-Cal audit functions. The audits were performed to identify and recover Medi-Cal overpayments to providers. The Interagency Agreement stated that "DHS will review all reports of overpayments identified by [the Controller] for policy and procedural implications." Interagency Agreement at 2 (July 1, 1997).

B. The Amended Interagency Agreement Between the Controller and the Department of Health Services

Effective July 1, 1998, DHS and the Controller amended the original Interagency Agreement ("Amended Interagency Agreement"). The Amended Interagency Agreement purportedly corrects the deficiencies found by this Court, in this and other related cases, and by the California Court of Appeal in *Doctor's Med. Lab., Inc. v. Connell,* 69 Cal. App. 4th 891 (1999). In particular, the Amended Interagency Agreement states that "DHS will exercise its authority as the Medicaid single state agency." Amended Interagency Agreement at 3-4 (July 1, 1998).

C. Events Leading Up to the Withhold

On September 9, 1998, the Controller conducted an audit of Plaintiff's records. Based upon this audit, the Controller sent a memorandum to DHS requesting DHS to "authorize a hold on all Medi-Cal payments to provider Clinical Care, Laboratory, Inc." pending completion of the State Controller's "current field review" on the provider. According to the October 6, 1998 Memorandum, the initial results of the Sate Controller's field review of Clinical Care's Medi-Cal payments indicated that the laboratory billed Medi-Cal for laboratory tests that were never ordered by two of the referring physicians. In addition, according to the memo, the Controller's auditors were unable to locate two other alleged referring physicians at the physician clinic address indicated on the laboratory's requisitions. Finally, according to the memo, the Controller found that 43% of the moneys paid to Clinical Care during May 1, 1998 and September 3, 1998, were erroneous.

By letter dated October 9, 1998, DHS informed Clinical Care that, based on the Controller's audit and review findings, DHS was temporarily withholding 100% of all Medi-Cal payments to Clinical Care pursuant to 42 C.F.R. § 455.23. The notice instructed Clinical Care to direct inquiries regarding the withhold action to a specified auditor in the Controller's office, but to submit written evidence in opposition to the action to a member the DHS's staff.

By a letter dated October 14, 1998, Clinical Care requested a hearing with DHS to challenge the temporary withholding of the Medi-Cal payments from Clinical Care. DHS's Office of Administrative Hearings and Appeals responded that it had no jurisdiction to review the withhold action since it was not based upon an actual audit disallowance but was simply a temporary withhold. It advised Clinical Care that its "remedy [was] in court." Shortly thereafter, Clinical Care filed the instant action in federal court. On January 14, 1999, Clinical Care's provider number was "inactivated."

By letter dated March 23, 1999, the Controller transmitted to Clinical Care its final audit report regarding the Medi-Cal claims paid to Clinical Care during the May 1, 1998 to September 3, 1998 time period. According to the Controller, Clinical Care had been overpaid for its services by almost $2 million. The letter also explained that as of the Court's preliminary injunction date and after the audit period, an additional amount of over $1 million dollars was authorized for payment to Clinical Care, and still subject to review. Some amount less than the 50% authorized by this Court's preliminary injunction order was withheld. The March 1999 audit report by the Controller's office sets forth a detailed explanation of the scope and methodology

used by the Controller's auditors to audit and review Clinical Care's Medi-Cal's claims and payments.

By letter dated April 9, 1999, Clinical Care requested an administrative hearing with DHS to challenge, among other things, the validity of the audit by the Controller on the grounds that the Controller lacks authority under federal law to perform Medi-Cal audits. The formal administrative hearing regarding Clinical Care's appeal was scheduled for April 19 and 20, 2000, but has been continued until some time in May. The Controller intends to present the results of her audit in this case to the administrative law judge in that action. Clinical Care challenges the Controller's ability to do so.

D. The Parties' Positions

Pursuant to Fed. R. Civ. P. 56, Plaintiff and Defendants both move this Court for summary judgment on the ground that there is no genuine issue as to any material fact. Plaintiff contends that, as a matter of law, it has a private right of action to enforce the provisions of the federal Medicaid law, and that those provisions prohibit the Controller from exercising discretion in administering the Medi-Cal program. Clinical Care requests that this Court both permanently enjoin DHS from delegating authority to the Controller, and permanently enjoin the Controller from continuing to pursue the finding of the Controller's audit and review of Clinical Care through the administrative appeal process.

On the other side, Defendants move for summary judgment on the ground that the withhold placed on Plaintiff's Medi-Cal payments was proper and in full compliance with federal Medicaid law. They contend that

because the actions were lawful, no injunction would be appropriate, and they should prevail on their summary judgment motion. They further contend that because Clinical Care is no longer licensed, this action is now moot and this Court lacks subject matter jurisdiction in the action. In addition, Defendants also bring a motion to dismiss the complaint under Fed. R. Civ. P. 12(h)(3). This second motion is based upon the same rationale and points to the same proofs as the summary judgment motion.[1]

III. Summary Judgment Standard

The standard set for summary judgment is clear. The Federal Rules of Civil Procedure provide for summary adjudication when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(e). Material facts which would preclude entry of summary judgment are those which, under applicable substantive law, may affect the outcome of the case. The substantive law will identify which facts are material. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The court must view the facts and draw inferences in the manner most favorable to the non-moving party. *See Chaffin v. United States*, 176 F.3d 1208, 1213 (9th Cir. 1999).

In a motion for summary judgment, "[i]f the party moving for summary judgment meets its initial burden of identifying for the court those portions of the materials on

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[1] Consequently, the Court will analyze these same facts and theory under the more difficult summary judgment standard.

file that it believes demonstrate the absence of any genuine issues of material fact," the burden of production then shifts so that "the nonmoving party must set forth, by affidavit or as otherwise provided in Rule 56, 'specific facts showing that there is a genuine issue for trial.'" *T.W. Elec. Service, Inc. v. Pacific Elec. Contractors Ass'n,* 809 F.2d 626, 630 (9th Cir. 1987) (citing *Celotex Corp. v. Catrett,* 477 U.S. 317 (1986)); *Kaiser Cement Corp. v. Fischbach & Moore, Inc.,* 793 F.2d 1100, 1103-04 (9th Cir. 1986). "[A] mere 'scintilla' of evidence will be insufficient to defeat a properly supported motion for summary judgment; instead the nonmoving party must introduce some 'significant probative evidence tending to support the complaint.'" *Fazio v. City of San Francisco,* 125 F.3d 1328, 1331 (9th Cir. 1997) (quoting *Anderson,* 477 U.S. at 249, 252).

In judging evidence at the summary judgment stage, the court does not make credibility determinations or weigh conflicting evidence. Rather, the court must draw all reasonable inferences in favor of the party against whom summary judgment is sought. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 587 (1986); *Intel Corp. v. Hartford Accident and Indem. Co.,* 952 F.2d 1551, 1558 (9th Cir. 1991). However, if no factual showing is made in opposition to a motion for summary judgment, the district court is not required to search the record sua sponte for some genuine issue of material fact. It may rely entirely on the evidence designated by the moving party showing no such triable issue. *See Guarino v. Brookfield Township Trustees,* 980 F.2d 399, 403 (6th Cir. 1992).

IV. Analysis

A. Plaintiff Clinical Care Has A Private Right of Action to Enforce Provisions of the Medicaid Act Which Prohibit the Delegation of Authority Outside of the Single State Agency

Regarding this issue, there is nothing about this Plaintiff or this case that distinguishes it from the many other related cases before it. Because Plaintiff's and Defendants' counsel have been the counsel of record in both *San Lazaro Association, Inc. v. Connell,* No. CV 98-6216 RJK, and *Simonyan, et al. v. Connell,* No. CV 99-2420 RJK, it will suffice to say that the reasoning in those cases similarly applies to this case.[2] Therefore, this Court finds that Plaintiff Clinical Care has a private right of action to enforce the provisions of the Medicaid Act, specifically, those provisions prohibiting the violation of the single state agency requirements.

B. Federal Medicaid Law Prohibits the Controller from Exercising Discretion in Administering the Medi-Cal Program

There is also nothing about this Plaintiff or this case that distinguishes it from the other related cases before it as to this issue of exercising discretion, either. The language of 42 C.F.R. § 431.10(e)(3) (1999) clearly states that

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[2] *See* November 12, 1999 Amended Memorandum of Decision and Order Granting Plaintiff's Motion for Summary Judgment in *San Lazaro Association, Inc. v. Connell,* No. CV 98-6216 RJK; *see also,* January 20, 2000 Memorandum of Decision and Order Granting Plaintiffs' Motion for Summary Judgment in *Simonyan, et al. v. Connell,* No. CV 99-2420 RJK.

> If other State . . . agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

Under the language of the regulation and the extended reasoning set forth in orders for both *San Lazaro Association, Inc. v. Connell,* No. CV 98-6216 RJK and *Simonyan, et al. v. Connell,* No. CV 99-2420 RJK,[3] this Court finds that the Controller has improperly exercised administrative discretion in connection with the administration of the Medi-Cal program.

C. This Action is Not Mooted by the Inactivation of Clinical Care's License

The real focus of this decision is whether, like in *San Lazaro,* the inactivation of Clinical Care's license caused the action to become moot. On February 2, 2000, the Court issued an order in *San Lazaro* granting Defendant's Motion to Alter or Amend the Memorandum of Decision and Order Granting Plaintiff's Motion for Summary Judgment ("Mooting Order"). The Court concluded in that case, that the action had to be dismissed because it had become moot.

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[3] *See* November 12, 1999 Amended Memorandum of Decision and Order Granting Plaintiff's Motion for Summary Judgment in *San Lazaro Association, Inc. v. Connell,* No. CV 98-6216 RJK; *see also,* January 20, 2000 Memorandum of Decision and Order Granting Plaintiffs' Motion for Summary Judgment in *Simonyan, et al. v. Connell,* No. CV 99-2420 RJK.

In arriving at its conclusion, the Court analyzed the effect the loss of licensure had on San Lazaro's ability to receive relief in federal court. After looking to the purpose behind the mootness doctrine, the Court determined that the requirement that the action be an ongoing case and controversy could not be met in *San Lazaro*. *See* Mooting Order at 3-6; *Diamond v. Charles,* 476 U.S. 54, 61 (1986) ("Article III of the Constitution limits the power of federal courts to deciding 'cases' and 'controversies.' "). The Court found that it could "fashion no relief that would afford Plaintiff any recovery for the harm that has been rendered. In particular, the permanent injunction requested by Plaintiff and previously awarded by this Court [would] have no effect on Plaintiff's harm." Mooting Order at 13.

For this determination, the Court analyzed both retroactive and prospective relief. The Court reiterated that under *Edelman v. Jordan,* 415 U.S. 651 (1974), the Eleventh Amendment bars Plaintiff from recovering a retroactive award of payments that should have been paid out, but were not, due to the unlawful withhold. Mooting Order at 5. However, in *San Lazaro,* unlike others before it, the Court also found that prospective relief was foreclosed as well. *Id.* at 5-6. Because San Lazaro was no longer licensed, it could not receive payments from the Medi-Cal program. Even if the Court had enjoined the defendants in *San Lazaro,* as an unlicensed provider, plaintiff would not be entitled to future claims. Consequently, since no relief could be fashioned, the action was moot. *Id.* at 8.

Defendants contend that just like in *San Lazaro,* no relief can be afforded to Clinical Care. They claim that since Clinical Care is no longer a licensed Medi-Cal provider, Clinical Care will not be able to receive payments

for any future claims. Consequently, they contend, prospective relief is unavailable and the action is moot. Plaintiff, however, attempts to distinguish *San Lazaro* by asserting that prospective relief *may* be afforded. Plaintiff contends that an injunction would preclude the Controller and DHS from using the audits at the administrative appeal scheduled for April 19-20, 2000, so that there is a live case controversy.

1. Discrepancy Between Prayer for Relief in the complaint and Current Potential Relief

In the Complaint filed by Clinical Care on October 15, 1998, Plaintiff requested that the Court order the following:

1. That the defendant Controller and her agents and employees be enjoined and restrained from continuing to withhold payments for services from Clinical Care and from auditing and reviewing Medi-Cal payments of Clinical Care;

2. That defendant Belshe and her agents and employees be enjoined from delegating discretionary authority concerning the Medi-Cal program to the Controller and be enjoined from enforcing the Interagency Agreement;

3. That defendant Belshe, her agents and employees, be enjoined and restrained from continuing to withhold Medi-Cal payments from Clinical Care and all such payments currently being withheld be released immediately;

4. That the actions of defendants be declared to be invalid and unlawful;

5. That Clinical Care be awarded compensatory damages in an amount according to proof at trial;

6. That Clinical Care be awarded punitive and exemplary damages;

7. That Clinical Care be awarded its cost of suit, including reasonable attorneys' fees; and

8. For such other and further relief as the Court deems to be just and proper.

The Complaint made no specific prayer that the Controller be enjoined from "continuing to pursue her adverse audit and review findings against Clinical Care and further prohibiting State DHS from using, either directly or indirectly, the State Controller's audit findings in . . . any . . . manner which is adverse to Clinical Care," as is now requested by Plaintiff. However, this discrepancy is not fatal.

The Supreme Court has made clear that "the burden of demonstrating mootness is a heavy one." *County of Los Angeles v. Davis,* 440 U.S. 625, 631 (1979). To that end, the Ninth Circuit has concluded that in deciding whether an action is moot, "the question is not whether the precise relief sought at the time the application for an injunction was filed is still available. The question is whether there can be any effective relief." *Northwest Envt'l Defense Ctr. v. Gordon,* 849 F.2d 1241, 1244-45 (citing to *Garcia v. Lawn,* 805 F.2d 1400, 1403 (9th Cir. 1986)). Because this Court could effectuate prospective relief, if warranted, by

enjoining the Controller from litigating her findings and enjoining DHS from relying on those findings, the action is not moot.

2. The Controller's Litigation of her Audit Findings in an Administrative Appeal Runs Contrary to the Medicaid Provisions.

The Amended Interagency Agreement violates the single State agency requirements of federal Medicaid law. The implementing regulation for the single State agency requirements provides that "[i]f other State . . . agencies or offices perform services for the Medicaid agency, they must not . . . substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." 42 C.F.R. § 431.10(e).

Notwithstanding this provision, the Amended Interagency Agreement allows the Controller to be "responsible for the tracking and resolution, including legal representation if needed, of the findings identified in [her] reviews, audits, or investigations. Such responsibility extends through, and includes, the administrative appeal process before the DHS Office of Administrative Hearings and Appeals (OAHA) under Welfare and Institutions Code section 14171." Amended Interagency Agreement 3. Thus, the Controller is allowed absolute discretion to audit, investigate, and litigate potentially invalid Medi-Cal claims made by Medi-Cal service providers. This Court continues to hold, as it did in *Simonyan,* "such sweeping powers very nearly define the complete exercise of discretionary authority." January 20, 2000 Memorandum of

Decision and Order Granting Plaintiffs' Motion for Summary Judgment in *Simonyan, et al. v. Connell,* No. CV 99-2420 RJK.

IV. Disposition

Because the action is not moot, Defendants' motions for dismissal under Fed. R. Civ. P. 12(h)(3) and summary judgment under Fed. R. Civ. P. 56 are *denied.* In addition, Plaintiff Clinical Care's motion for summary judgment is *granted.*

IT IS SO ORDERED.

DATE: APR 21 2000

/s/ Robert J. Kelleher
Robert J. Kelleher
United States
District Judge

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SAN LAZARO ASSOCIATION, INC. dba BIOMEDICAL LAB.,
Plaintiff,
v.
KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA,
Defendant.

CASE NO. 98-6216 RJK

MEMORANDUM OF DECISION AND ORDER GRANTING DEFENDANT'S MOTION TO ALTER OR AMEND AMENDED MEMORANDUM OF DECISION AND ORDER GRANTING PLAINTIFF SAN LAZARO ASSOCIATION'S MOTION FOR SUMMARY JUDGMENT

(Filed Feb. 2, 2000)

Defendant Kathleen Connell, Controller of the State of California ("Controller") has requested that this Court alter or amend its Amended Memorandum of Decision and Order Granting Plaintiff San Lazaro Association's Motion for Summary Judgment ("MD&O") dated November 15, 1999. On January 31, 2000, this Court heard argument from counsel regarding Defendant's motion to alter or amend as well as two other motions. The Court has considered the moving and responding papers as well as the argument of counsel. For the reasons set forth below, the Court GRANTS Defendant's motion to alter or amend the MD&O.

I. Introduction and Procedural Summary

On July 31, 1998, Plaintiff San Lazaro Association, Inc. ("San Lazaro"), dba Biomedical Laboratory ("Biomedical")

filed a Complaint for Injunctive and Declaratory Relief and Damages Under the Civil Rights Act, 42 U.S.C. § 1983 et seq., ("Complaint") against the Controller.

Plaintiff alleged that the State Department of Health Services ("DHS") was wrongfully withholding Medi-Cal payments to San Lazaro based on an audit performed by the Controller in violation of federal law, and this Court's Memorandum of Decision and Order in the related case of *Health Line Clinical Lab. v. Connell*, CV 98-1620 RJK (C.D. Cal. Apr. 9, 1998) ("*Health Line*").

This Court agreed with Plaintiff San Lazaro, and on November 15, 1999 granted Plaintiff's motion for summary judgment and enjoined Defendant from conducting audits against Medi-Cal health care providers. Defendant now requests that the Court alter or amend its MD&O granting Plaintiff's motion for summary judgment. Defendant bases her motion upon the following arguments:

1) The Eleventh Amendment is a jurisdictional bar to the State Controller's action;

2) The action is moot;

3) The Court's Decision and Order is based on a misapprehension of plaintiff's position as set forth in the Complaint;

4) The Court's Decision and Order is based on a misapprehension of defendant's position;

5) The Court's Decision and order mistakenly decides issues outside those presented for determination in the Complaint;

6) The Court's Decision and Order is based on factual error; and

7) The Court's Decision and Order is based on legal error.

II. Analysis

A. The Eleventh Amendment's Grant of Sovereign Immunity is Not a Jurisdictional Bar to an Action Brought by Plaintiff San Lazaro

As is set forth more expansively in the Court's Memorandum of Decision and Order Denying Defendant's Motion to Dismiss the Complaint filed February ___, 2000, the Eleventh Amendment's grant of sovereign immunity is *not* a jurisdictional bar to an action brought by Plaintiff. A recent Ninth Circuit opinion, *Hill v. Blind Indus. & Sery*, 179 F.3d 754 (9th Cir. 1999), definitively holds that an agency waives any Eleventh Amendment immunity it might possess by participating in extensive pretrial procedures and not raising an objection until after a substantive decision is made. *See id.* at 756-760. Defendant Controller, an agent of the state, vigorously litigated the action, filing briefs, replies, responses and many other such documents at every opportunity. Now, after this Court has granted summary judgment adverse to Defendant's interests, Defendant chooses to raise the Eleventh Amendment immunity argument. This Court, following clear Ninth Circuit precedent, will not entertain the Controller's request.

B. The Action is Moot

1. Plaintiff Cannot Receive Payments for Past or Future Services Rendered

"Article III of the Constitution limits the power of federal courts to deciding 'cases' and 'controversies.'"

Diamond v. Charles, 476 U.S. 54, 61, 106 S. Ct. 1697, 1703, 90 L. Ed. 2d 48 (1986). The Constitution requires "the party who invokes the court's authority to show that he personally has suffered some actual or threatened injury . . . and that the injury fairly can be traced to the challenged action and is likely to be redressed by a favorable decision.'" *Id.* at 70, 106 S. Ct. at 1708, 90 L. Ed. 2d 48 (citations omitted). Moreover, the "case" or "controversy" created when a plaintiff files suit "must be extant at all stages of review, not merely at the time the complaint is filed." *Preiser v. Newkirk*, 422 U.S. 395, 401, 95 S. Ct. 2330, 2334, 45 L. Ed. 2d 272 (1975). The action of such controversy moots the action.

Although the mootness doctrine effects a significant loss of economy, the Supreme Court has continued to adhere to the doctrine. In *Friends of the Earth, Inc. v. Laidlaw Environmental Services (TOC), Inc.*, ___ S. Ct. ___, 2000 WL 1630715 (U.S., Jan 12, 2000) (NO. 98-822), the Supreme Court pointed out that often "by the time mootness is an issue, the case has been brought and litigated, often (as here) for years. To abandon the case at an advanced stage may prove more wasteful than frugal." *Id.* at *15. The purpose of the doctrine of mootness, to conserve limited judicial resources, is turned on its head when dilatory actions are allowed to stand.

Nevertheless, the Supreme Court has also been quick to point out that "this argument from sunk [judicial] costs does not license courts to retain jurisdiction over cases in which one or both of the parties plainly lacks a continuing interest." *Id.* It has long been settled that a federal court has no authority "to give opinions upon moot questions or abstract propositions, or to declare principles or rules of law which cannot affect the matter in issue in the case

before it." *Church of Scientology of Cal. v. United States*, 506 U.S. 9, 12, 113 S. Ct. 447, 121 L. Ed. 2d 313 (1992)), *cert. denied*, 522 U.S. 1117, 118 S. Ct. 1055, 140 L. Ed. 2d 118 (1998) (quoting *Mills v. Green*, 159 U.S. 651, 653, 16 S. Ct. 132, 133, 40 L. Ed. 293 (1895)).

It appears to the Court that though much has been invested into this case, there is no ongoing "case or controversy" in this action. This Court can fashion no relief that would afford Plaintiff any recovery for the harm that has been rendered. In particular, the permanent injunction requested by Plaintiff and previously awarded by this Court will have no effect on Plaintiff's harm.

a. Retroactive Awards Are Not Permitted

This Court has held time and again that, due to Eleventh Amendment constraints, Plaintiff may not receive a retroactive award of payments properly paid out during the unlawful withhold. To hold otherwise would be contrary to the mandate in *Edelman v. Jordan*, 415 U.S. 651, 94 S. Ct. 1347, 39 L. Ed. 2d 662 (1974). The Supreme Court held in *Edelman* that "a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment." *Id.* at 663, 94 S. Ct. 1347, 1356, 39 L. Ed. 2d 662. The only exceptions to this prohibition occur when Congress abrogates state immunity through statutory enactments or when a monetary award is not a form of retroactive compensation for past illegal acts but is only a "necessary consequence of compliance in the future" with court orders that are prospective in nature. *Id.* at 668, 94 S. Ct. at 1358, 39 L. Ed. 2d 662. Under *Edelman*, relief

limited to future injunctive relief would certainly be allowed.

b. Future Services Will Not Receive Reimbursement

However, *Edelman*'s limitation to prospective relief effectively bars San Lazaro from any relief whatsoever. A practical analysis of the record as it now sits before the Court reveals that Plaintiff will not be able to receive any prospective relief, either. One of requirements necessary to receive reimbursement as a Medical service provider is a valid California Clinical Laboratory License. Because Plaintiff voluntarily canceled his laboratory license on November 30, 1998, Plaintiff is no longer entitled to any Medi-Cal payments for any future services.[1] At this point, the lifting of the withhold placed by the DHS based upon the Controller's wrongful audit will not benefit Plaintiff. In essence, San Lazaro cannot receive the money due to it for past services under the Eleventh Amendment and it cannot receive money for future services because it is unlicensed.

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[1] The Court has searched its records to determine if any discussion of the license cancellation was made by either attorney before this motion. It could find no mention of the cancellation within the papers submitted. Had the parties brought to the Court's attention the voluntary cancellation of the laboratory license back in 1998 when it occurred, hundreds of hours invested by the Court would not have been squandered.

2. No Exception to the Mootness Doctrine Applies

Once found to be moot, the only way that Plaintiff's case can survive is if an exception to the mootness doctrine applies. Unfortunately for Plaintiff, no such doctrine applies in this case.

a. This Situation is Not "Capable of Repetition Yet Evading Review"

An exception exists if the situation is "capable of repetition yet evading review." As the Supreme Court recently explained, this doctrine that allows cases that are moot to be maintained "applies only in exceptional situations, where the following two circumstances [are] simultaneously present: (1) the challenged action [is] in its duration too short to be fully litigated prior to cessation or expiration, and (2) there [is] a reasonable expectation that the same complaining party [will] be subject to the same action again." *Spencer v. Kemna*, 523 U.S. 1, 17, 118 S. Ct. 978, 988, 140 L. Ed. 2d 43 (1998) (internal quotation marks and citations omitted) (alterations in original).

In applying this doctrine, it is apparent that this case does not fit within this narrow exception. In determining if an issue satisfies the repetition/evasion exception, courts have recognized that "evading review" means that the "underlying action is almost certain to run its course before either [the Ninth Circuit Court of Appeals] or the Supreme Court can give the case full consideration." *Miller v. California Pacific Med. Ctr.*, 19 F.3d 449, 453-54 (9th Cir. 1994). The Supreme Court has held that 18 months was not enough time for complete judicial review.

See First Nat'l Bank v. Bellotti, 435 U.S. 765, 774, 98 S. Ct. 1407, 55 L. Ed. 2d 707 (1978).

At first glance it would seem that all plaintiffs like San Lazaro who would institute an action against the Controller for wrongful audits would satisfy the evasion prong. Surely if the plaintiffs rely primarily on Medi-Cal reimbursements for their livelihood, they would necessarily go out of business well before their cases could be fully litigated. Nevertheless, this intuition is belied by the facts. Currently this Court has on its docket a case with very similar facts to the one at bar. *See Simonyan v. Connell*, CV 99-2420 RJK (C.D. Cal.). Notwithstanding the extreme hardship that must be involved, the plaintiff in that action is still properly licensed and capable of receiving prospective relief. It should be noted that the 18 month time period of *First National* has not yet expired in that case. Nevertheless, it seems that this is not a claim that will necessarily always evade review.

Further, an application of these facts to the second prong of repetition/evasion exception demonstrates much more clearly that Plaintiff's claim does not qualify for this exception. The second prong of the repetition/evasion exception requires some indication that the challenged conduct will be repeated. *See Greenpeace Action v. Franklin*, 14 F.3d 1324, 1329 (9th Cir. 1993). It is extremely unlikely that this prong will be met. Plaintiff is no longer licensed so it will not be entitled to Medi-Cal payments and therefore will not be subject to any wrongful audit of these payments. Further, there has been no assertion that Plaintiff will attempt to reapply for a new license or form a new business that could be subject to a wrongful audit by the Controller. Consequently, the wrong committed by Defendant is unlikely to be repeated against this Plaintiff.

Accord Sze v. I.N.S., 153 F.3d 1005, 1009 (9th Cir. 1998) (holding that exception to mootness doctrine based on the wrong being capable of repetition yet evading review did not apply to applicants for naturalization who were naturalized after bringing action to compel Immigration and Naturalization Service (INS) to timely act on their applications; because applicants had been naturalized, it was highly unlikely they would have to repeat the process).

b. Defendant Did Not Voluntarily Cease the Unlawful Conduct

A defendant's voluntary cessation of the alleged unlawful conduct also could present an exception to the mootness doctrine if "there is [a] reasonable expectation that the wrong will be repeated." *Public Utilities Comm'n v. F.E.R.C.*, 100 F.3d 1451, 1460 (9th Cir. 1996) (citation and internal quotation marks omitted). Defendant has definitely not voluntarily stopped auditing Medi-Cal providers and, therefore, this mootness exception does not apply.

C. Conclusion

In sum, the Plaintiff's cancellation of its laboratory license mooted its request for injunctive and declaratory relief. No mootness exception applies. Under these circumstances, the action no longer presents a live case or controversy as required by Article III of the Constitution.

Because the Court has found that Plaintiff's action is moot, it need not address any further arguments proffered by Defendant.

III. Disposition

For all of the reasons set forth above this Court VACATES its previous Amended Memorandum of Decision and Order Granting Plaintiff San Lazaro Association's Motion for Summary Judgment and DISMISSES the case as moot.

IT IS SO ORDERED.

DATE: February 1, 2000 /s/ Robert J. Kelleher
ROBERT J. KELLEHER
United States District Judge

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must –

* * *

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

* * *

(9) provide –

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which

recipients of medical assistance under the plan may receive care or services.

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

* * *

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view of maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

* * *

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under

the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

* * *

(37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

* * *

42 C.F.R. § 430.10 The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for HCFA to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

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42 C.F.R. § 430.12 Submittal of State plans and plan amendments.

* * *

(c) *Plan amendments.* (1) The plan must provide that it will be amended whenever necessary to reflect –

* * *

(ii) Material changes in State law, organization, or policy, or in the State's operation of the Medicaid program. For changes related to advance directive requirements, amendments must be submitted as soon as possible, but no later than 60 days from the effective date of the change to State law concerning advance directives.

* * *

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42 C.F.R. § 430.20 Effective dates of State plans and plan amendments.

For purposes of FFP, the following rules apply:

(a) *New plans.* The effective date of a new plan –

(1) May not be earlier than the first day of the quarter in which an approvable plan is submitted to the regional office; and

(2) With respect to expenditures for medical assistance, may not be earlier than the first day on which the plan is in operation on a statewide basis.

(b) *Plan amendment.* (1) For a plan amendment that provides additional services to individuals eligible under the approved plan, increases the payment amounts for services already included in the plan, or makes additional groups eligible for services provided under the approved plan, the effective date is determined in accordance with paragraph (a) of this section.

(2) For a plan amendment that changes the State's payment method and standards, the rules of § 447.256 of this chapter apply.

(3) For other plan amendments, the effective date may be a date requested by the State if HCFA approves it.

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42 C.F.R. § 431.10 Single State agency.

(a) *Basis and purpose.* This section implements section 1902(a)(5) of the Act, which provides for designation of a single State agency for the Medicaid program.

(b) *Designation and certification.* A State plan must –

(1) Specify a single State agency established or designated to administer or supervise the administration of the plan; and

(2) Include a certification by the State Attorney General, citing the legal authority for the single State agency to –

(i) Administer or supervise the administration of the plan; and

(ii) Make rules and regulations that it follows in administering the plan or that are binding upon local agencies that administer the plan.

(c) *Determination of eligibility.* (1) The plan must specify whether the agency that determines eligibility for families and for individuals under 21 is –

(i) The Medicaid agency; or

(ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia), or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands.

(2) The plan must specify whether the agency that determines eligibility for the aged, blind, or disabled is –

(i) The Medicaid agency;

(ii) The single State agency for the financial assistance program under title IV-A (in the 50 States or the District of Columbia) or under title I or XVI (AABD), in Guam, Puerto Rico, or the Virgin Islands; or

(iii) The Federal agency administering the supplemental security income program under title XVI (SSI). In this case, the plan must also specify whether the Medicaid agency or the title IV-A agency determines eligibility for any groups whose eligibility is not determined by the Federal agency.

(d) *Agreement with Federal or State agencies.* The plan must provide for written agreements between the Medicaid agency and the Federal or other State agencies that determine eligibility for Medicaid, stating the relationships and respective responsibilities of the agencies.

(e) *Authority of the single State agency.* In order for an agency to qualify as the Medicaid agency –

(1) The agency must not delegate, to other than its own officials, authority to –

(i) Exercise administrative discretion in the administration or supervision of the plan, or

(ii) Issue policies, rules, and regulations on program matters.

(2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.

(3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the

authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency.

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42 C.F.R. § 431.11 Organization for administration.

(a) *Basis and purpose.* This section, based on section 1902(a)(4) of the Act, prescribes the general organization and staffing requirements for the Medicaid agency and the State plan.

(b) *Medical assistance unit.* A State plan must provide for a medical assistance unit within the Medicaid agency, staffed with a program director and other appropriate personnel who participate in the development, analysis, and evaluation of the Medicaid program.

(c) *Description of organization.* (1) The plan must include –

(i) A description of the organization and functions of the Medicaid agency and an organization chart;

(ii) A description of the organization and functions of the medical assistance unit and an organization chart; and

(iii) A description of the kinds and number of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities.

(d) *Eligibility determined by other agencies.* If eligibility is determined by State agencies other than the Medicaid agency or by local agencies under the supervision of

other State agencies, the plan must include a description of the staff designated by those other agencies and the functions they perform in carrying out their responsibility.

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42 C.F.R. § 431.610 Relations with standard-setting and survey agencies.

(a) *Basis and purpose.* This section implements –

(1) Section 1902(a)(9) of the Act, concerning the designation of State authorities to be responsible for establishing and maintaining health and other standards for institutions participating in Medicaid; and

(2) Section 1902(a)(33) of the Act, concerning the designation of the State licensing agency to be responsible for determining whether institutions and agencies meet requirements for participation in the State's Medicaid program.

(3) Section 1919(g)(1)(A) of the Act, concerning responsibilities of the State for certifying the compliance of non-State operated NFs with requirements of participation in the State's Medicaid program.

(b) *Designated agency responsible for health standards.* A State plan must designate, as the State authority responsible for establishing and maintaining health standards for private or public institutions that provide services to Medicaid recipients, the same State agency that is used by the Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare (see 42 CFR 405.1902). The requirement for establishing and maintaining standards does not apply

with respect to Christian Science sanitoria operated, or listed and certified, by the First Church of Christ Scientist, Boston, Mass.

(c) *Designated agency responsible for standards other than health standards.* The plan must designate the Medicaid agency or other appropriate State authority or authorities to be responsible for establishing and maintaining standards, other than those relating to health, for private or public institutions that provide services to Medicaid recipients.

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42 C.F.R. § 447.45 Timely claims payment.

(a) *Basis and purpose.* This section implements section 1902(a)(37) of the Act by specifying –

(1) State plan requirements for –

(i) Timely processing of claims for payment;

(ii) Prepayment and postpayment claims reviews; and

(2) Conditions under which the Administrator may grant waivers of the time requirements.

(b) *Definitions. Claim* means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.

Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with

errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

A *shared health facility* means any arrangement in which –

(1) Two or more health care practitioners practice their professions at a common physical location;

(2) The practitioners share common waiting areas, examining rooms, treatment rooms, or other space, the services of supporting staff, or equipment;

(3) The practitioners have a person (who may himself be a practitioner) –

(i) Who is in charge of, controls, manages, or supervises substantial aspects of the arrangement or operation for the delivery of health or medical services at the common physical location other than the direct furnishing of professional health care services by the practitioners to their patients; or

(ii) Who makes available to the practitioners the services of supporting staff who are not employees of the practitioners; and

(iii) Who is compensated in whole or in part, for the use of the common physical location or related support services, on a basis related to amounts charged or collected for the services rendered or ordered at the location or on any basis clearly unrelated to the value of the services provided by the person; and

(4) At least one of the practitioners received payments on a fee-for-service basis under titles V, XVIII, and XIX in an amount exceeding $5,000 for any one month during the preceding 12 months or in an aggregate amount exceeding $40,000 during the preceding 12 months.

The term does not include a provider of services (as specified in § 489.2(b) of this chapter), a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act), a hospital cooperative shared services organization meeting the requirements of section 501(e) of the Internal Revenue Code of 1954, or any public entity.

Third party is defined in § 433.135 of this chapter.

(c) *State plan requirements.* A State plan must (1) provide that the requirements of paragraphs (d), (e)(2), (f) and (g) of this section are met; and

(2) Specify the definition of a claim, as provided in paragraph (b) of this section, to be used in meeting the requirements for timely claims payment. The definition may vary by type of service (e.g., physician service, hospital service).

(d) *Timely processing of claims.* (1) The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.

(2) The agency must pay 90 percent of all clean claims from practitioners, who are in individual or group practice or who practice in shared health facilities, within 30 days of the date of receipt.

(3) The agency must pay 99 percent of all clean claims from practitioners, who are in individual or group

practice or who practice in shared health facilities, within 90 days of the date of receipt.

(4) The agency must pay all other claims within 12 months of the date of receipt, except in the following circumstances:

(i) This time limitation does not apply to retroactive adjustments paid to providers who are reimbursed under a retrospective payment system, as defined in § 447.272 of this part.

(ii) If a claim for payment under Medicare has been filed in a timely manner, the agency may pay a Medicaid claim relating to the same services within 6 months after the agency or the provider receives notice of the disposition of the Medicare claim.

(iii) The time limitation does not apply to claims from providers under investigation for fraud or abuse.

(iv) The agency may make payments at any time in accordance with a court order, to carry out hearing decisions or agency corrective actions taken to resolve a dispute, or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

(5) The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.

(6) The date of payment is the date of the check or other form of payment.

(e) *Waivers.* (1) The Administrator may waive the requirements of paragraphs (d) (2) and (3) of this section upon request by an agency if he finds that the agency has

shown good faith in trying to meet them. In deciding whether the agency has shown good faith, the Administrator will consider whether the agency has received an unusually high volume of claims which are not clean claims, and whether the agency is making diligent efforts to implement an automated claims processing and information retrieval system.

(2) The agency's request for a waiver must contain a written plan of correction specifying all steps it will take to meet the requirements of this section.

(3) The Administrator will review each case and if he approves a waiver, will specify its expiration date, based on the State's capability and efforts to meet the requirements of this section.

(f) *Prepayment and postpayment claims review.* (1) For all claims, the agency must conduct prepayment claims review consisting of –

(i) Verification that the recipient was included in the eligibility file and that the provider was authorized to furnish the service at the time the service was furnished;

(ii) Checks that the number of visits and services delivered are logically consistent with the recipient's characteristics and circumstances, such as type of illness, age, sex, service location;

(iii) Verification that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed;

(iv) Verification that a payment does not exceed any reimbursement rates or limits in the State plan; and

(v) Checks for third party liability within the requirements of § 433.137 of this chapter.

(2) The agency must conduct postpayment claims review that meets the requirements of parts 455 and 456 of this chapter, dealing with fraud and utilization control.

* * *

Subpart A – Medicaid Agency Fraud Detection and Investigation Program

42 C.F.R. § 455.12 State plan requirement.

A State plan must meet the requirements of §§ 455.13 through 455.23.

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§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have –

(a) Methods and criteria for identifying suspected fraud cases;

(b) Methods for investigating these cases that –

(1) Do not infringe on the legal rights of persons involved; and

(2) Afford due process of law; and

(c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.

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§ 455.14 Preliminary investigation.

If the agency receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation.

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§ 455.15 Full investigation.

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must take the following action, as appropriate:

(a) If a provider is suspected of fraud or abuse, the agency must –

(1) In States with a State Medicaid fraud control unit certified under subpart C of part 1002 of this title, refer the case to the unit under the terms of its agreement with the unit entered into under § 1002.309 of this title; or

(2) In States with no certified Medicaid fraud control unit, or in cases where no referral to the State medicaid fraud control unit is required under paragraph (a)(1) of this section, conduct a full investigation or refer the case to the appropriate law enforcement agency.

(b) If there is a reason to believe that a recipient has defrauded the Medicaid program, the agency must refer the case to an appropriate law enforcement agency.

(c) If there is reason to believe that a recipient has abused the Medicaid program, the agency must conduct a full investigation of the abuse.

---

§ 455.16 Resolution of full investigation.

A full investigation must continue until –

(a) Appropriate legal action is initiated;

(b) The case is closed or dropped because of insufficient evidence to support the allegations of fraud or abuse; or

(c) The matter is resolved between the agency and the provider or recipient. This resolution may include but is not limited to –

(1) Sending a warning letter to the provider or recipient, giving notice that continuation of the activity in question will result in further action;

(2) Suspending or terminating the provider from participation in the Medicaid program;

(3) Seeking recovery of payments made to the provider; or

(4) Imposing other sanctions provided under the State plan.

---

§ 455.23 Withholding of payments in cases of fraud or willful misrepresentation.

(a) *Basis for withholding.* The State Medicaid agency may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medicaid program. The State Medicaid agency may withhold payments without first notifying the provider of

its intention to withhold such payments without first notifying the provider of its intention to withhold such payments. A provider may request, and must be granted, administrative review where State law so requires.

(b) *Notice of withholding.* The State agency must send notice of its withholding of program payments within 5 days of taking such action. The notice must set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning its ongoing investigation. The notice must:

(1) State the payments are being withheld in accordance with this provision;

(2) State that the withholding is for a temporary period, as stated in paragraph (c) of this section, and cite the circumstances under which withholding will be terminated;

(3) Specify, when appropriate, to which type or types of Medicaid claims withholding is effective; and

(4) Inform the provider of the right to submit written evidence for consideration by the agency.

(c) *Duration of withholding.* All withholding of payment actions under this section will be temporary and will not continue after:

(1) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation by the provider; or

(2) Legal proceedings related to the provider's alleged fraud or willful misrepresentation are completed.

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 654-0391

December 17, 1999

Ms. Linda Minamoto
Associate Regional Administrator
DHHS Health Care Financing Administration
Division of Medicaid-Region IX
75 Hawthorne Street, Fourth Floor
San Francisco, CA 94105

Dear Ms. Minamoto:

STATE PLAN AMENDMENT 99-011

The Department of Health Services is submitting the enclosed State Plan Amendment to recognize the California State Controllers Office and their performance of audits of Medi-Cal program providers.

For this amendment, we are requesting an effective date of July 1, 1998. If you have any questions on this amendment, please contact Mr. Joseph A. Kelly, Chief of the Medi-Cal Policy Division, at (916) 657-1542.

Sincerely,

/s/ Stan Rosenstein
Stan Rosenstein
Acting Deputy Director
Medical Care Services

Enclosure

STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING
ADMINISTRATION
DEPARTMENT OF HEALTH AND
HUMAN SERVICES

1. TRANSMITTAL NUMBER: 99-011

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE: July 1, 1998

5. TYPE OF PLAN MATERIAL (*Check One*):

   [ ] NEW STATE PLAN

   [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN

   [x] AMENDMENT

   COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

   a. FFY ____ $ ____
   b. FFY ____ $ ____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 1.2-A (page labeled as 25 – Audits & Investigations)

9. PAGE NUMBER OF THE SUPERVISED PLAN SECTION OR ATTACHMENT (*If Applicable*) Same

10. SUBJECT OF AMENDMENT: State Controller's Office-Authority to Audit

11. GOVERNOR'S REVIEW (*Check One*):

    [ ] GOVERNOR'S OFFICE REPORTED NO

    [ ] COMMENT

    [ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

    [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

    [X] OTHER AS SPECIFIED: Governor's Office does not wish to review State Plan amendments.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
    /s/ Stan Rosenstein

13. TYPED NAME: Stan Rosenstein

14. TITLE: Acting Deputy Director

15. DATE SUBMITTED: 12/17/99

16. RETURN TO: Department of Health Services
    714 P Street, Room 1640
    Sacramento, CA 95814

    Attn: State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME

22. TITLE:

REMARKS:

Attachment 1.2-A

AUDITS AND INVESTIGATIONS DIVISION

* * *

F. The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action.

No. 99-011 Approval Date: ___ Effective Date ___

[LOGO] **DEPARTMENT OF HEALTH & HUMAN SERVICES**

[Address Omitted in Printing]

Dec. 17, 1999

Stan Rosenstein, Acting Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

Dear Mr. Rosenstein:

Enclosed is a copy of California State plan amendment (SPA) No. 99-011, which we have approved effective July 1, 1998, as you requested. SPA 99-011 amends the State plan to reflect the fact that the State Controller's Office performs audits of Medi-Cal expenditures on behalf of the Department of Health Services (DHS).

Our review of SPA No. 99-011 was conducted in accordance with the requirements of section 1902(a)(5) of the Social Security Act (the Act) and the regulatory provisions at 42 CFR 431.10 and 431.11.

Should you have any questions regarding our approval of this SPA, please contact Pat Daley at (415) 744-3592.

Sincerely,

/s/ Karen Fuller for Linda Minamoto
Associate Regional Administrator
Division of Medicaid

Enclosure

cc: Elliott Weisman, HCFA, Center for Medicaid and State Operations Barbara Hardiman, DHS, California State Plan Coordinator

STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER: 99-011

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE: July 1, 1998

5. TYPE OF PLAN MATERIAL (*Check One*):

   [ ] NEW STATE PLAN

   [ ] AMENDMENT TO BE CONSIDERED AS NEW PLAN

   [x] AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:

   a. FFY _____ $_____

   b. FFY _____ $_____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 1.2-A (page labeled as 25 – Audits & Investigations)

9. PAGE NUMBER OF THE SUPERVISED PLAN SECTION OR ATTACHMENT (*If Applicable*) Same

10. SUBJECT OF AMENDMENT: State Controller's Office-Authority to Audit

11. GOVERNOR'S REVIEW (*Check One*):

    [ ] GOVERNOR'S OFFICE REPORTED NO COMMENT

    [ ] COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

    [ ] NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

    [x] OTHER AS SPECIFIED: Governor's Office does not wish to review State Plan amendments.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

    /s/ Stan Rosenstein

13. TYPED NAME: Stan Rosenstein

14. TITLE: Acting Deputy Director

15. DATE SUBMITTED: 12/17/99

16. RETURN TO: Department of Health Services
    714 P Street, Room 1640
    Sacramento, CA 95814

    Attn: State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12/17/99

18. DATE APPROVED: 12/17/99

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 1998

20. SIGNATURE OF REGIONAL OFFICIAL: /s/ Karen Fuller for

21. TYPED NAME: Linda Minamoto

22. TITLE: Associate Regional Administrator
Division of Medicaid

REMARKS:

Attachment 1.2-A

AUDITS AND INVESTIGATION DIVISION

* * *

F. The State Controller's Office will perform audits of Medi-Cal expenditures on behalf of DHS and will submit its findings and recommendations to DHS for appropriate action.

Approval Date: Dec. 17, 1999 Effective Date: 7/1/98

DOCTOR'S MEDICAL LABORATORY, INC. *v.* CONNELL
69 Cal.App.4th 891; 81 Cal.Rptr.2d 829 [Feb. 1999]

[No. B119355. Second Dist., Div. Seven. Feb. 1, 1999.]

DOCTOR'S MEDICAL LABORATORY, INC., Plaintiff and Appellant, v. KATHLEEN CONNELL, as Controller, etc., Defendant and Appellant.

COUNSEL

Hooper, Lundy & Bookman and Patric Hooper for Planitiff [sic] and Appellant.

Daniel E. Lungren, Attorney General, Linda A. Cabatic, Assistant Attorney General, Marsha A. Bedwell and Christopher C. Foley, Deputy Attorneys General, for Defendant and Appellant.

OPINION

NEAL, J. –

SUMMARY

Federal Medicaid law barred California's Department of Health Services (DHS) – as the "single agency" designated to administer federally funded Medicaid/Medi-Cal payments for medical services for the poor and indigent – from delegating to the state Controller the audit of claims by medical service providers, and the withholding of alleged overpayments.

FACTS AND PROCEEDINGS IN TRIAL COURT

Appellant Doctor's Medical Laboratory, Inc. (hereafter "Doctor's") is a now-defunct firm which formerly provided doctors with laboratory analysis of specimens of blood, urine, and the like. A large portion of Doctor's income was derived from Medi-Cal patients. Medi-Cal is a State of California program to subsidize medical care for the poor and indigent. Doctor's brought this action to compel

respondent Connell, Controller of California, to release approximately $3 million which Doctor's claimed was due for services to Medi-Cal patients.

Medi-Cal payments to patients are funded with federal monies provided under the Medicaid legislation. To obtain federal monies the states must comply with the federal statutory and regulatory requirements of Medicaid. (42 U.S.C. § 1396a(a); *Wilder* v. *Virginia Hospital Assn.* (1990) 496 U.S. 498, 502, [110 S.Ct. 2510, 2513-2514, 110 L.Ed.2d 455].)

Federal law specifies that a state *must designate a single agency* to administer its Medicaid plan (42 U.S.C. § 1396a(a)(5)), and further, forbids the designated agency from delegating, except to its own officials, authority to exercise discretion in administering the plan. (42 C.F.R. § 431.10(e)(1)-(3) (1998).) Federal regulations permit the designated agency to use services of other state agencies, but *not to delegate administrative discretion* to such agencies: "If other State . . . agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to the application of policies, rules, and regulations issued by the Medicaid agency." (42 C.F.R. § 431.10(e)(3) (1998).)

In addition to the single agency and nondelegation requirements, federal law requires states participating in Medicaid to establish procedures to investigate abuses while protecting providers. (42 U.S.C. §§ 1396a(a)(3), (a)(42); 42 C.F.R. §§ 447.200, 447.202, 455.12-23 (1998).) Carrying out these requirements, California's Welfare and Institutions Code requires DHS to have an administrative appeals process "to review grievances or complaints

arising from the findings of an audit or examination. . . . " (Welf. & Inst. Code, § 14171, subd. (a).) California regulations state that "[a] provider may request a hearing . . . to examine any disputed audit or examination finding which results in an adjustment to Medi-Cal program reimbursement. . . . " (Cal. Code Regs, tit. 22, § 51017.) DHS cannot recoup alleged overpayments to a provider until the administrative appeals process is complete, absent special circumstances not present in this case. (Cal. Code Regs, tit. 22, §§ 51017, 51047, subd. (a); Welf. & Inst. Code, § 14170.5, subd. (a).)

California's Medicaid plan, submitted in 1993, certified to the federal government that California's Department of Health Services is the single agency which administers Medi-Cal. A DHS organization chart submitted with California's plan identified a "Fiscal Intermediary Management Division" of DHS. An accompanying description of the Fiscal Intermediary Management Division stated that its Provider Services Section was responsible for all contacts between providers and the State concerning payments, and that its On-Site Management Branch was responsible for audits and reviews concerning accurate payments of claims. The Medi-Cal organization chart also identified an Audits and Investigations Division, whose responsibilities were described in the plan to include identifying excess payments to medical service providers, and taking corrective action.

DHS contracted with a private entity, called EDS, to review and process provider claims for payment for services rendered to Medi-Cal patients. Federal regulations permit the contracting-out of this function to a private concern. (42 C.F.R. §§ 434.4-434.10 (1998); Welf. & Inst. Code, §§ 14000.3, 14104.3, subd. (a), 14105; Cal. Code

Regs., tit. 22, §§ 50007, 51529.) EDS reviews the claims, determines the amount owed, approves the claim, and submits it to respondent Controller for issuance of a check or "warrant" to the provider.

Until mid-1997 the Controller's services to DHS for Medi-Cal were apparently limited to issuing checks, a nondiscretionary activity. In June 1997 DHS entered an Interagency Agreement with the Controller under which the Controller agreed to perform audits to identify overpayments to providers, and to take corrective action, presumably withholding sums believed to constitute overpayment. The agreement stated that "DHS will review all reports of overpayments identified by [Controller] for policy and/or procedural implications."

In late November 1997 Doctor's filed the present suit seeking, inter alia, a writ of mandate compelling the Controller to pay Doctor's approximately $3 million allegedly earned and owed for services to Medi-Cal patients. Doctor's alleged that in September 1997, without notice to Doctor's, the Controller commenced withholding payments due Doctor's and already approved for payment by EDS. Doctor's urged that DHS had unlawfully delegated its Medi-Cal powers to the Controller, and that the Controller had violated the administrative procedures for dealing with overpayments. Doctor's further claimed that the Controller's refusal to pay the claims had driven Doctor's out of business.

In response to Doctor's suit, the Controller contended that she was justified in withholding payments because Doctor's claims contained insufficient information concerning services provided, and reflected unusually high claims amounts for the services provided.

The trial court rejected Doctor's claim that DHS had illegally delegated audit and overpayment remedial functions to the Controller. However, the trial court found that the Controller was obliged under Government Code section 926.15, subdivision (a), to pay provider claims approved by EDS, less contested amounts, within 30 days after receipt. It granted a writ of mandate ordering the Controller to comply with section 926.15, subdivision (a).

Both sides appealed from the judgment.

DISCUSSION

(1) As a preliminary matter, we reject the Controller's argument that Doctor's lacks standing to bring the present claims. The Controller relies on *Sobky* v. *Smoley* (E.D. Cal 1994) 855 F.Supp. 1123, a federal case holding that methadone recipients and providers lack standing under 42 United States Code section 1983 to enforce the "single state agency" requirement of Medicaid law, because that requirement benefits them only indirectly (through more efficient administration of Medicaid). However Doctor's sued here for a writ of mandate, made available under California Code of Civil Procedure section 1085. While section 1983 of 42 United States Code requires violation of a private right, privilege, or immunity to confer standing, section 1085 of the California Code of Civil Procedure creates a broad right to issuance of a writ of mandate "to compel performance of an act which the law specifically enjoins." Section 1085 "is available not only to those who have enforceable private rights, but to those who are `beneficially interested' parties within the meaning of Code of Civil Procedure section 1086." (*California Homeless & Housing Coalition* v. *Anderson* (1995)

31 Cal.App.4th 450, 458 [37 Cal.Rptr.2d 639] [per Chin, J., homeless coalition has standing despite *Sobsky* rule to seek mandamus compelling state agency to comply with federal AFDC law].)

Doctor's is a "beneficially interested party" and has standing to pursue its action in mandamus against the Controller.

We turn to the merits.

(2) State participation in Medicaid is voluntary, but once a state elects to participate and receive federal funds, it is obliged to fully comply with federal statutes and regulations. (*Frank* v. *Kizer* (1989) 213 Cal.App.3d 919, 923 [261 Cal.Rptr. 882].)

(3) As noted above, federal Medicaid statutes and regulations require designation of a single state agency to administer a state's Medicaid program, and further, forbid delegation of the agency's power to make administrative judgments or decisions about the application of the agency's policies, rules and regulations. Consistent with these provisions, California's Medi-Cal plan affirmed compliance with the single agency requirement and stated that auditing of provider claims and recapture of overpayments would be done by DHS.

The interagency agreement, however, authorized the *Controller* to audit provider claims and "take corrective action." Delegation of these powers to the Controller was contrary to DHS's representation to the federal government (in DHS's Medicaid plan) that *audits and corrective action would be DHS's province*. Further, the authority extended to the Controller to "take corrective action" was

authority to change or disapprove prior decisions by DHS's agent (EDS) to pay provider claims. This transfer of authority from DHS to the Controller violated the federal statutory and regulatory bar on delegation by the "single designated agency" of discretionary authority. It improperly empowered the Controller to "change or disapprove" administrative decisions by DHS and its agent.

The interagency agreement's recitation that "DHS will review all reports of overpayments identified by [Controller] for policy and/or procedural implications" does not save the delegation of authority from violating federal law. The express ban on delegating discretionary power contains no exception permitting delegation so long as decisions are later "reviewed" (in some unspecified manner) by the designated "single agency." The bar to delegation of discretionary power would be easily circumvented if such a provision in an interagency agreement were given effect.

The Controller could not lawfully exercise power to audit provider payments and withhold alleged excesses.[1]

The Controller argues that she has an independent duty under California law to supervise payments from the treasury of California. While this is generally true, California modified this duty with respect to Medi-Cal payments by accepting federal monies and agreeing to be bound by federal laws requiring designation of a single California agency to administer those payments.

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[1] While it is not controlling precedent, we note that the federal District Court for the Central District of California reached the same conclusion as we do, on the same reasoning, in its unpublished decision filed April 9, 1998, in *Health Line Clinical Laboratory, Inc.* v. *Connell*, (U.S. Dist.Ct. (C.D.Cal.)) No. CV-98-1620-RJK.

Neither side has cited legislative history or case law discussing the legislative and regulatory reasons for the single agency and non-delegation rules. But the circumstances of the present case suggest some of these reasons. First, such rules, if adhered to, avoid the delay entailed when several state agencies in succession review claims before payment is made. Here, DHS's agent, EDS, approved the claims, but then the Controller held them up. Second, the rules offer a degree of assurance that state agencies reviewing provider claims will have knowledge and expertise concerning medical expense claims and the peculiar rules and regulations which govern Medicaid claims. By contrast, a non-specialized agency such as the Controller, newly embarked on the business of reviewing medical provider claims, might well lack the expertise needed for prompt fair review.

And of course, prompt, knowledgeable, fair review and payment of provider claims are essential to the basic statutory purpose to provide medical care to the indigent and elderly. Private providers will soon be discouraged from offering Medicaid services if they are not paid promptly and fairly for their services. Indeed, providers will not be *able* to provide such services if they go out of business because the state improperly withholds payments – as Doctor's alleges occurred here.

In accordance with the foregoing, we will modify the trial court's judgment to require that the Controller release all sums which EDS has approved for payment to Doctor's, without prejudice to subsequent audits and claims for overpayment by DHS, in compliance with the governing rules and regulations.

DISPOSITION

The judgment of the trial court is modified to require Controller to forthwith pay to Doctor's all amounts approved for payment by the Department of Health Service's Fiscal Intermediary, EDS. As so modified, the judgment is affirmed. Plaintiff and Appellant shall recover its costs on appeal.

LILLIE, P.J, and JOHNSON, J., concur.

A petition for a rehearing was denied March 3, 1999, and the petition of defendant and appellant for review by the Supreme Court was denied May 26, 1999. Kennard, J., and Brown, J., were of the opinion that the petition should be granted.

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

HEALTH LINE CLINICAL LABORATORY, INC.; AND RCJ MEDICAL SERVICES, INC., Plaintiffs, v. KATHLEEN CONNELL, CONTROLLER OF THE STATE OF CALIFORNIA, ET AL., Defendants.	Case No.: CV-98-1620-RJK MEMORANDUM OF DECISION & ORDER GRANTING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION (Filed April 9, 1998)

The Court, having read and considered the papers filed in connection with Plaintiffs' Motion for Preliminary Injunction, and after hearing oral argument on April 6, 1998, hereby orders as follows.

I. INTRODUCTION

Plaintiffs Health Line Clinical Laboratory, Inc. ("Health Line") and RCJ Medical Services, Inc. ("RCJ"), filed their Complaint in this Court on March 6, 1998, seeking injunctive, declaratory, and mandamus relief under 42 U.S.C. § 1983, naming as Defendants Kathleen Connell, Controller of the State of California ("Controller"), Kimberly Belshe, Director of the California Department of Health Services, and Donna Shalala, the Secretary of the United States Department of Health and Human Services. Plaintiffs filed their Motion for Preliminary Injunction on March 12, 1998 ("Motion"), seeking to enjoin the Controller from usurping the authority of the

California Department of Health Services ("State DHS"), the single state Medicaid agency.[1] Plaintiffs allege that the Controller, pursuant to an Interagency Agreement with State DHS (*see* Compl. Ex. I), performed an audit of Plaintiffs' laboratories, determined that Plaintiffs had been overpaid by the Medi-Cal program, and unilaterally began withholding from Plaintiffs all pending Medi-Cal payments, in violation of the notice and review procedures required under the applicable federal Medicaid law and regulations.[2]

Previously, on January 29, 1998, RCJ had filed in Sacramento County Superior Court a Petition for Writ of Mandate and Temporary Stay Order. On February 9, 1998, a hearing was there held, and the matter was taken under submission. On February 11, 1998, Health Line filed its Petition for Writ of Mandate in the same court, along with separate Applications for Stay Order and for Alternative Writ of Mandate. On February 13, 1998, a hearing was held, the matter again taken under submission. The Superior Court consolidated the two cases, and on March 4, 1998, denied both RCJ's and Health Line's Applications for Stay Order, because "Petitioners have not shown a sufficient likelihood of success on the merits." (Ruling on Submitted Matters, Mar. 4, 1998, Motion Attach.) A hearing on the merits of the RCJ and Health

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[1] Under 42 U.S.C. § 1396a(a)(5), the Medicaid program is required to be administered exclusively by a designated single state agency. Under California's Medicaid program, known as Medi-Cal (*see* CAL. WELF. & INST. CODE § 14000 *et seq.*) the single state agency is State DHS.

[2] Since Plaintiffs' Motion seeks no relief from Defendants Kimberly Belshe and Donna Shalala, neither has filed a substantive response to this Motion.

Line Petitions for Writ of Mandate was set for April 9, 1998.

Plaintiffs allege that their attempt to obtain preliminary relief in state court was unsuccessful because that court believed the Controller's general fiscal responsibilities under state law supersede the governing federal Medical law and regulations.[3] Thus, Plaintiffs contend, the state court ignored the supremacy of federal law with respect to the administration of the Medicaid system.

II. ANALYSIS

Relief under 42 U.S.C. § 1983 is not limited to federal constitutional violations but also may be based on violations of a federal statute.[4] Yet because § 1983 is addressed to the deprivation of "rights, privileges or immunities" and not merely to the violation of federal law, Plaintiffs must show that the federal law violated creates enforceable rights within the meaning of § 1983. *Golden State Transit*

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[3] CAL. GOV'T CODE § 12410, outlining the duties of the Controller, provides in relevant part:

> The Controller shall superintend the fiscal concerns of the state. . . . shall audit all claims against the state, and may audit the disbursement of any state money, for correctness, legality, and for sufficient provisions of law for payment. . . . [T]he Controller may make such field or other audit of any claim or disbursement of state money as may be appropriate.

[4] 42 U.S.C. § 1983 provides a right of action against any person who, under color of state law, deprives another of "any rights, privileges or immunities secured by the Constitution and laws [of the United States]." *See also Maine v. Thiboutot*, 448 U.S. 1, 6-8, 100 S.Ct. 2502, 2505-06 (1980).

Corp. v. City of Los Angeles, 493 U.S. 103, 106, 110 S.Ct. 444, 448 (1989).

In determining whether statutory provisions create enforceable rights, the district court in *Sobky v. Smoley*, 855 F.Supp. 1123 (E.D. Cal. 1994), synthesized the two leading Supreme Court cases on the subject, *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 110 S.Ct. 2510 (1990) and *Suter v. Artist M.*, 503 U.S. 347, 112 S.Ct. 1360 (1992), and applied a single test. According to *Sobky*, the provision sought to be enforced must be (1) intended to benefit Plaintiffs; (2) mandatory rather than precatory; (3) not so vague as to be "beyond the competence of the judiciary to enforce" (*Wilder*, 110 S.Ct. at 2517); and (4) the statutory language must be specific and detailed enough so that the court may "examine exactly what is required of the States" (*Suter*, 112 S.Ct. at 1367). 855 F.Supp. at 1133.

In *Sobky*, providers and recipients or potential recipients of Medicaid funded methadone maintenance treatment services challenged, under § 1983, California's practice of allowing individual counties to determine whether, and in what amount, to provide such drug abuse treatment services. The court granted defendants' motion to dismiss plaintiffs' claim under 42 U.S.C. § 1396a(a)(5), ruling that the plaintiffs could not maintain a private right of action under the Civil Rights Act to enforce the single state agency provision of federal Medicaid law. The court determined that by requiring "the establishment or designation of a single State agency to administer or to supervise the administration of" the state plan for medical assistance, § 1396a(a)(5) was not phrased in terms of benefiting recipients. "At most, Medicaid recipients and providers are incidental beneficiaries of the single state agency requirement, to the extent that it results in an

efficiently operating Medicaid program." 855 F. Supp. at 1146. The court did, however, allow plaintiffs' action to proceed, and even granted preliminary injunctive relief, with respect to other Medicaid regulations not at issue herein.

Plaintiffs, although they question *Sobky*'s ruling that the single state agency requirement was not intended to benefit providers, seek herein to enforce other Medicaid provisions, those prohibiting the violation of the single state agency's rules; specifically, 42 C.F.R. § 431.10(e), which provides:

> In order for an agency to qualify as the Medicaid Agency –
>
> (1) The agency must not delegate, to other than its own officials, authority to –
>
> (i) Exercise administrative discretion in the administration or supervision of the plan, or
>
> (ii) Issue policies, rules and regulations on program matters.
>
> (2) The authority of the agency must not be impaired if any of its rules, regulations, or decisions are subject to review, clearance, or similar action by other offices or agencies of the State.
>
> (3) If other State or local agencies or offices perform services for the Medicaid agency, they must not have the authority to change or disapprove any administrative decision of that agency, or otherwise substitute their judgment for that of the Medicaid agency with respect to application of policies, rules, and regulations issued by the Medicaid agency.

Plaintiffs argue that this provision was intended to protect Medi-Cal providers, such as themselves, from falling victim to unauthorized state action, such as that alleged against the Controller. The Controller argues, perhaps disingenuously, that

> plaintiffs fail to demonstrate that the Medicaid laws and regulations prohibit the State Controller from exercising her constitutional and statutory obligations to audit the expenditures of State monies. . . . and further fail to demonstrate any basis in which the State Controller's actions have interfered with the discretion of the Director [of State DHS].

(Opp'n at 20-21.)

The Controller ignores the fact that "[a]lthough participation in the [Medicaid] program is voluntary, participating States must comply with certain requirements imposed by the Act and regulations promulgated by the Secretary of Health and Human Services." *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502; 110 S.Ct. 2510, 2513 (1990) (emphasis added). This goes a long way toward disposing of the Controller's argument.

Because of the supremacy of federal law in this area, no interagency agreement could give the Controller more power than the State DHS has the authority to delegate. In fact, the Interagency Agreement itself requires the Controller to abide by various Welfare and Institutions Code sections, as well as procedural regulations of State DHS, which were clearly intended for the benefit of providers. One of these regulations, 22 C.C.R. § 51047, prohibits the recoupment of an alleged Medi-Cal overpayment until a demand for repayment is issued following an

audit, and requires the deferment of recoupment efforts against noninstitutional providers, such as independent clinical laboratories herein, allowing said providers to retain all payments pending the outcome of an administrative appeal, should the providers request one. This regulation has clearly not been followed by the Controller, in violation of 42 C.F.R. § 431.10(e).

Plaintiffs also allege the Controller violated 42 C.F.R. § 455.13, which requires the single state agency establish "[m]ethods and criteria for identifying suspected fraud cases . . . that – (1) Do not infringe on the legal rights of persons involved; and (2) Afford due process of law." The Controller does not dispute that she has withheld all Medi-Cal payments to Plaintiffs, totaling over a million dollars, without affording either Plaintiff an opportunity to be heard. In addition, the Controller has violated 42 C.F.R. § 455.23, which sets forth the procedures the single state agency must follow if it decides to withhold payments in cases of suspected fraud or willful misrepresentation. Specifically, the Controller did not give the five days prior notice required before initiating the total withhold, did not set forth the general allegations as to the nature of the withholding action, did not inform Plaintiffs of their right to submit any written evidence, and, more fundamentally, performed these non-delegable functions of the single state agency without State DHS' initiation or approval.

The Controller does not contest these allegations. Instead, the Controller counters, in most conclusory terms, that the "other federal regulations which authorize only the single state agency to withhold funds . . . derive their authority from the single state agency requirement, and thus, are similarly barred." (Opp'n at 20.) The Court

disagrees. Since these regulations were undoubtedly intended to benefit Plaintiffs, and not merely to promote the efficient administration of the state plan, it follows that this § 1983 action may be maintained, as these provisions are mandatory, not at all vague, and specific and detailed enough so that the court may "examine exactly what is required of the States." The Controller, or any other state agent, may be enjoined in federal court from acting inconsistently with the policies and procedures of State DHS with respect to the Medi-Cal program, as required under 42 C.F.R. 431.10(e), and must comply with 42 C.F.R. §§ 455.13 & 455.23 if Medi-Cal funds are to be withheld from Plaintiffs.[5]

a. Eleventh Amendment

The Controller contends that the Eleventh Amendment to the United States Constitution's grant of sovereign immunity applies to the case at bar, because although the state is not itself a named defendant, the funds Plaintiffs seek to have released will of necessity come from the state treasury.[6]

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[5] Plaintiffs contend the Controller has all but admitted she lacks the authority exercised herein, in that she originally directed her audit report of Health Line to State DHS back in 1997, recommending at that time that State DHS take some action. "However, after months went by without State DHS taking the action she recommended, the Controller decided to act on her own." (Mot. at 6.)

[6] U.S. CONST. amend. XI provides:

> The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State.

(Continued on following page)

> The general rule is that a suit is against the sovereign if 'the judgment sought would expend itself on the public treasury or domain, or interfere with the public administration,' or if the effect of the judgment would be 'to restrain the Government from acting, or to compel it to act.'

Pennhurst State School & Hosp. v. Halderman, 465 U.S. 89, 101 n.11; 104 S.Ct. 900, 908 n.11 (1984) (citations omitted).

The Controller argues that any order of this Court requiring the retroactive award of benefits withheld would amount to damages, "measured in terms of monetary loss resulting from a past breach of a legal duty on the part of the defendant state officials," and would thus be barred under *Edelman v. Jordan*, 415 U.S. 651, 668; 94 S.Ct. 1347, 1358 (1974). The Court agrees.

It is equally clear to the Court, and the parties seem to agree, that an order compelling the release of Medi-Cal payments for all ongoing and future services would not be prohibited under the Eleventh Amendment, as "the fiscal consequences to state treasuries [would be] the necessary result of compliance with [a decree] which by [its] terms [was] prospective in nature." *See Edelman*, 94 S.Ct. at 1358 (relying on *Ex Parte Young*, 209 U.S. 123, 28 S.Ct. 441 (1908)); Reply at 3 n.2; Opp'n at 9.

The Eleventh Amendment's prohibition extends as well to suits brought in federal court against a state by its own citizens. *Hans v. Louisiana*, 134 U.S. 1, 15, 10 S.Ct. 504, 507 (1890).

b. Colorado River Doctrine

In the alternative, Defendant Controller moves this Court to abstain under the *Colorado River* doctrine from any action, given the parallel state proceedings. *See Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 96 S.Ct. 1236 (1976). In *Colorado River*, the Supreme Court began its analysis by proclaiming that

> Abstention from the exercise of federal jurisdiction is the exception, not the rule. . . . an extraordinary and narrow exception to the duty of a District Court to adjudicate a controversy properly before it. . . . justified . . . only in the **exceptional circumstances** where the order to the parties to repair to the state court would clearly serve an important countervailing interest.

424 U.S. at 813 (internal quotations and citations omitted) (emphasis added).

The *Colorado River* court went on to recognize "principles rest[ing] on considerations of wise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation" to be considered in assessing the appropriateness of abstention in the event of concurrent jurisdiction with a state court. 424 U.S. at 817 (internal quotations, alterations, and citations omitted).

The factors to be considered in the *Colorado River* 'exceptional circumstances' test include:

[1] whether either court has assumed jurisdiction over a *res*;

[2] the relative convenience of the forums;

> [3] the desirability of avoiding piecemeal litigation; [ ]
>
> [4] the order in which the forums obtained jurisdiction. . . .
>
> [5] whether state or federal law controls and
>
> [6] whether the state proceeding is adequate to protect the parties' rights

Nakash v. Marciano, 882 F.2d 1411, 1415 (9th Cir. 1989) (citing *Colorado River*, 424 U.S. at 818 and *Moses H. Cone Memorial Hosp. v. Mercury Constr.*, 460 U.S. 1, 25-26, 103 S.Ct. 927, 941-42 (1983)).

Moses H. Cone makes clear that the *Colorado River* exceptional circumstances test "does not rest on a mechanical checklist, but on a careful balancing of the important factors as they apply in a given case, with the balance heavily weighted in favor of the exercise of jurisdiction." 460 U.S. at 16.

> [W]e emphasize that our task in cases such as this is not to find some substantial reason for the *exercise* of federal jurisdiction . . . [but] rather . . . to ascertain whether there exist 'exceptional' circumstances, the 'clearest of justifications' that can suffice under *Colorado River* to justify the *surrender* of that jurisdiction.

Id. at 25-26 (emphasis in original).

The first two *Colorado River* factors do not apply to the case at bar. Defendant Controller, however, makes much of the third factor, the risk of piecemeal litigation. The Controller argues that Plaintiffs, having failed to obtain preliminary relief in state court, brought this action for preliminary injunction, to be heard just three days

before a hearing on the merits had been scheduled in state court. The Court acknowledges the duplication of judicial efforts, and the possibility, even likelihood, of reaching results different from the state court.

The Controller also points out that, under the fourth factor, not only did the state Court obtain jurisdiction first, but that the prevention of forum shopping is an appropriate consideration under *Colorado River*, citing *American Int'l Underwriters, (Philippines), Inc. v. Continental Ins. Co.*, 843 F.2d 1253, 1259 (9th Cir. 1988). The Court recognizes that the failure to obtain preliminary relief in state court is what led Plaintiffs to file in federal court.

The fifth factor, whether federal or state law controls, is the substantive ground of contention upon which this case rests, the determination of which goes far towards deciding its outcome. If Plaintiffs are correct, and the state court has ignored federal supremacy in the area of Medicaid law, then that court has implicitly determined that state law controls. This Court finds that federal law controls, and the risk that federal supremacy in the area of Medicaid law is not being recognized weighs heavily in favor of this Court exercising its jurisdiction in this § 1983 action.

With respect to the final *Colorado River* factor, the Controller argues that since Plaintiffs originally filed in state court, there was an implicit acknowledgement that the state proceeding was adequate to protect their rights. The Court finds that despite Plaintiffs' initial expectation as to the adequacy of the state court setting, time has shown that their rights under federal Medicaid law and regulations are not being adequately protected in that forum.

The Court finds abstention under the *Colorado River* doctrine to be inappropriate, noting that

> the "unflagging obligation" of the federal courts to exercise the jurisdiction given to them. . . . is particularly weighty when those seeking a hearing in federal court are asserting . . . their right to relief under 42 U.S.C. § 1983. Under such circumstances conflicting results, piecemeal litigation, and some duplication of judicial effort is the unavoidable price of preserving access to the federal relief which Section 1983 assures.

Toyar v. Billmeyer, 609 F.2d 1291, 1293 (9th Cir. 1980) (citations omitted).

At oral argument, counsel for the Controller went so far as to concede the impropriety of federal court abstention in the § 1983 context.

c. Preliminary Injunctive Relief

In order to obtain preliminary injunctive relief, the moving party must demonstrate either "(1) a combination of probable success on the merits and the possibility of irreparable injury or (2) that serious questions are raised and the balance of hardships tips sharply in its favor." *Los Angeles Mem'l Coliseum Comm'n v. National Football League*, 634 F.2d 1197, 1201 (9th Cir. 1980) (citation omitted). The Controller adds that the public interest is a necessary factor to be considered under either approach, citing *Caribbean Marine Services Co., Inc. v. Baldrige*, 844 F.2d 668, 674 (9th Cir. 1988).

It is clear to the Court, and the Controller does not contest, that federal law and regulations have not been complied with. Plaintiffs, having gone beyond merely

raising serious questions, have in fact demonstrated a likelihood of success on the merits.

In making their showing of irreparable harm, Plaintiffs have demonstrated convincingly that if the Controller is not ordered to stop withholding Medi-Cal payments, both Health Line and RCJ will go out of business. Both laboratories are very dependent on Medi-Cal revenues for their continued operations, since the majority of their patients are Medi-Cal patients. Plaintiff Health Line has already been forced to sell its satellite laboratory in Ventura, California, to raise the funds necessary to continue to operate, and if the withhold continues, will have to lay off its 200 employees. (Burkhartsmeier Decl. at 8-9.) Plaintiff RCJ, who has had funds withheld since September, 1997, "has had to lay off various employees and to substantially reduce the working hours of others. . . . The owners of RCJ have been unable to draw any salaries and have had to borrow money to continue to live and to operate RCJ." (Gordo Decl. at 3.)

The Controller contends that "the public interest in preserving over $1 million in withheld payments from RCJ and Health Line weighs heavily against plaintiffs," as Plaintiffs' tenuous financial condition is quite likely to result in an uncollectible judgment should the Court ultimately rule in the Controller's favor. (Opp'n at 18-19.) Although the Court recognizes the public's interest in these funds, it finds persuasive Plaintiffs' argument that "the single state Medicaid agency has determined [by enacting 22 C.C.R. § 51047, discussed above] that the interest of a provider in continuing to receive Medi-Cal payments for services pending the outcome of an audit appeal outweighs the interest of the State retaining suspected overpayments." (Reply at 11.)

It would hardly be equitable for this Court to allow the Controller, after having placed Plaintiffs in the desperate financial straits in which they now find themselves, to use that circumstance against them in arguing for the denial of preliminary relief. Plaintiffs have met their burden for obtaining preliminary injunctive relief.

III. RULING

The Court hereby GRANTS Plaintiffs' Motion for Preliminary Injunction. In deference to the state of California's sovereign immunity under the Eleventh Amendment to the United States Constitution, the Court will not order the Controller to disgorge the Medi-Cal funds withheld to date. However, the Court will waive the bond required under FED. R. CIV. P. 65(c)[7], as fitting within the recognized exception for "cases involving the enforcement of 'public interest' arising out of 'comprehensive federal health and welfare statutes.'" *Pharmaceutical Soc'y of New York v. New York Dep't of Soc. Serv.*, 50 F.3d 1168, 1174 (2d Cir. 1995) (citations omitted).[8] The public interest is served by protecting

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[7] Rule 65(c) provides, in relevant part:

> No restraining order or preliminary injunction shall issue except upon the giving of security by the applicant, in such sum as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any party who is found to have been wrongfully enjoined or restrained.

[8] *See id.* at 1174-75:

> in *Temple University v. White*, 941 F.2d 201 (3rd Cir. 1991), [ ] the court upheld the waiver of the bond requirement in a case in which a hospital had brought suit to ensure that Pennsylvania complied with the Medicaid Act. . . . [In

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providers who "serve a disproportionate share of low income patients," as do Plaintiffs herein. 50 F.3d at 1174. "To the extent that [providers] do not receive full compensation, some are likely to drop out of the Medicaid program and reduce the number of providers of health care to poor individuals." *Id.* at 1175.

The Court has in mind the allegations of criminal misconduct against one of the Plaintiff's principals, and the risk that some of the funds released pursuant to this Order may never be recovered. However, given the current state of the record, the Court finds that the public interest in protecting against a state official's intrusion upon federally protected rights, procedural or otherwise, as well as those public interest factors discussed above, outweighs that risk. The Court notes the security the Controller already retains in the wrongfully withheld funds, amounting to more than one million dollars.

The Controller is ordered to cease withholding Medi-Cal funds from Plaintiffs immediately, for all laboratory services rendered by Plaintiffs from the date of this Order, subject to further order of this Court. The Court fully expects that an administrative hearing will be held, as required by 22 C.C.R. § 51047, applied to the Controller through 42 C.F.R. § 431.10(e). The Controller, in all future actions with respect to Medi-Cal audits performed, shall comply fully with all federal Medicaid laws and regulations,

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Pharmaceutical Society,] While the district court found that the Society was unlike a traditional public interest group because it was pursuing its pecuniary interests [by suing] to ensure that pharmacies providing Medicaid services would receive full compensation for those activities[, the court upheld] the district court's waiver of the bond requirement.

as well as with all applicable Welfare and Institutions Code and California Code of Regulations sections, as it agreed to do in the Interagency Agreement with State DHS, and as required under federal law.

The parties shall notify the Department of Health Services' Office of Hearings and Appeals of this disposition, in the hope that it will assist in expediting the administrative review process for both Plaintiffs.

IT IS SO ORDERED.

Dated: APR -9 1998

/s/ Robert J. Kelleher
Robert J. Kelleher
United States
District Judge